VETERANS' ADMINISTRATION'S RESEARCH ON AGING

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BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

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HOUSE OF REPRESENTATIVES

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VETERANS' ADMINISTRATION'S RESEARCH ON AGING

WEDNESDAY, JUNE 13, 1984

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Mollohan, Penny, Rowland, Hammerschmidt, Hillis, Bilirakis, and Johnson.

Also present: Representative Shelby.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. Good morning. The subcommittee will come to order.

This is the third and last of a series of hearings on the VA's research programs. Today, we will receive testimony on the VA's research program on aging.

Veterans 65 years of age or older now total about 4.2 million veterans, or nearly one out of every seven living veterans. Their numbers are expected to peak at about 9 million by the year 1999. By the year 2000, approximately two out of every three males over the age of 65 will be veterans. This "greying" of American veterans will place a heavy demand for medical care upon the Veterans' Administration, since older people need and use health care services more than do members of other age groups.

The VA is exploring a number of approaches to deal with this problem, one of which is to reduce the demand for acute health care services by providing alternative outpatient or home-based modalities. The VA's geriatric research effort is directed toward learning more about the biological processes of aging and using that knowledge to address the physical and mental defects resulting from age-related disorders. They have been conducting geriatric research for many years, and the VA program was strengthened with the establishment of the Geriatric Research, Education, and Clinical Centers Program.

Public Law 96-330, which originated in this committee, authorized the establishment of 15 GRECCs, and there are presently 8 GRECCs in existence. Each of these centers does specialized research, such as neurobiology, immunology, and other related kinds of concerns. This morning we will hear testimony from the VA researchers about their activities concerning this problem we will all face someday.

I would now like to recognize the ranking minority member of the subcommittee, the Honorable John Paul Hammerschmidt, for any remarks he may wish to make at this time.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. **Hammerschmidt**. Thank you, Mr. Chairman.

The hearing this morning culminates an effort by our subcommittee to focus on research programs of the Veterans' Administration. This effort has been an intense one, and I congratulate you, Mr. Chairman, for your leadership in such a vital area.

Mr. Chairman, today's hearing is primarily concerned with research on the needs of the aging veteran. Hopefully, we will hear about what the VA has done, is doing, and will do with respect to treatment or prevention of conditions that are usually considered to be associated with the aging process.

Mr. Chairman, I think it is a great credit to medicine in our country that our people's life span has increased so dramatically over this century. Of course, that increase has brought on new challenges to medicine in terms of forecasting future treatment modalities.

With respect to veterans, I think our Nation is indeed fortunate that we already have in place an excellent hospital and outpatient treatment program that can meet that challenge head on. In this regard, the VA has embarked on long-range planning in this area to add to its existing programs of treatment of the elderly. It would be my hope, Mr. Chairman, that VA would soon share with us its latest planning documents so that we can work with the agency in their implementation.

One final thought, Mr. Chairman. All too often, those who think of the medical needs of the aging think primarily in terms of long-term, chronic-type care. We ought never to forget that those who are elderly often require care for acute conditions. Therefore, in my view, VA ought to move very cautiously with respect to converting acute care beds to long-term chronic beds. It seems to me that we need a carefully thought out mix of each.

Mr. Chairman, on a personal note, I play a dual role with respect to this area. I am a ranking member on the House Select Committee on Aging, as well as ranking member on this committee. From both perspectives, I see research making vital contributions to the future of medicine in this country. I am, therefore, anxious to hear our witnesses this morning and look forward to their testimony.

While I have the podium, Mr. Chairman, I note that you're getting ready to introduce a very distinguished witness, and I am delighted to join you in welcoming her. I know of her long-term interest in the aging phenomenon in this country and how to handle it. I particularly note her expertise and the research that she has done with very professional people in Alzheimer's disease. So I want to join you in welcoming her.

Mr. **Edgar**. Thank you very much.

Are there any additional opening statements? If not, our first witness this morning will be Hon. Olympia Snowe of the second District of Maine. Olympia, we are very pleased to have you here this morning and we invite you to proceed. The full text of your statement will be made a part of the record, without objection.

STATEMENT OF HON. OLYMPIA J. SNOWE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mrs. **Snowe**. I appreciate that, Mr. Chairman, and I will summarize my remarks.

First of all, I do want to express my appreciation to this committee for giving me the opportunity to discuss an issue concerning neurological research, and that is, of course, the case of Alzheimer's disease victims who also happen to be veterans.

Many Members of Congress, Mr. Chairman, and members of this committee, have been concerned with the prevalence of Alzheimer's disease in this country, and to that end the Congress did respond to that need last year by appropriating additional money to the National Institute of Health, with the stipulation that priority would be given to research on Alzheimer's disease. In addition, the Veterans' Administration was also directed to increase its research on Alzheimer's disease as well. So I am pleased that this committee is going to be exploring the current state-of-the-art.

While research activities are, indeed, critical and are underway, there is another facet and dimension to this entire issue that I think needs to be addressed, and that is, of course, the treatment and care of those veterans who are afflicted with Alzheimer's disease. So the question that is asked most frequently is what kind of treatment is available to veterans in this country who already suffer from that disease.

There are many alarming statistics concerning Alzheimer's overall, and the fact is I would like to cite a few for this committee just to give you an indication of how widespread this disease is in this country.

First of all, it is the fourth leading cause of death in the United States after heart attacks, strokes, and cancer. One out of six of us later on in life can expect to be afflicted with Alzheimer's. Presently, about 4 million Americans suffer from this disease as well.

Unfortunately, this disease takes its toll in many respects. The disease runs its course from 3 to 15 years, and that includes a total memory loss, personality changes—and later in the latter stages, a total loss of bodily functions. Included in that, of course, is erratic and even angry behavior as well. So it is a very difficult disease, not only for the victim, but for the victim's family.

We know that in the next 40 years the aging population in this country will double to about 43 million for those over 65 or older. That is precisely the age group that is going to be afflicted by Alzheimer's, the most susceptible, to Alzheimer's disease. The fact is there are a number of people in this country who are affected in the 40–50 age category as well.

We can also expect the veterans' population, as you mentioned, Mr. Chairman, in your opening statement, those in the category of 65 or older, to be 9 million, which will double the present veteran population of those in that age category by the year 2000. Also, experts predict that two out of three American males who will be 65 or older also will be veterans. So I think the Veterans' Administration has a serious challenge before it in terms of providing the kind of care and treatment to those veterans with Alzheimer's disease.

Included with my statement is testimony that was given to me by a woman in the State of Maine by the name of Mrs. Marilyn Paige, who has a husband who served in the armed services for 25 years. Her husband, at the age of 56, has Alzheimer's disease; he probably had it for 8 to 10 years before it was properly diagnosed, and that is another dimension to this entire problem.

But, nevertheless, she has attempted to put him in a Veterans' Hospital in the State of Maine, in Togus. In fact, she has tried at several different intervals. But Togus, because of the current limitations of law, has only been able to give him so much care and cannot go above and beyond that care.

Mrs. Paige is in a Catch 22 situation. Her husband is a retiree, so the Veterans' Hospital cannot provide him costs of nursing home care. They suggested that the military pay for that care because he is a retiree, although the military has said: "We don't pay for that nursing home care." So he's in a situation where they financially cannot meet their obligations. She is also in a position of having to sell off her life insurance in order to meet that care, and eventually become eligible for medicaid help.

He is at Togus at this point. Togus has been more than responsive to the needs of Mrs. Paige's husband. That hasn't always been the case in some of the veterans' hospitals across this country. So, again, I am not here to denegrate the kind of care that is being provided by the veterans hospital. I hope that is not misunderstood. But I do think it is important that the committee recognize that there is not a consistent nationwide policy with respect to the treatment of veterans who attempt to get admission in a veterans' hospital.

The current policy, as I understand it, concerning veterans hospitals is, of course, they give priority to those service-connected disability veterans. That is, of course, both appropriate and right. Those veterans with nonservice-connected disabilities are only admitted to veterans hospitals to the extent that, one, resources are available, two, if they are 65 years or older, or three, they are indigent. That is exactly why I have introduced the legislation that I have. I think it is important that the veterans hospitals in this country have more flexibility in providing long-term care for those veterans who suffer from this tragic illness.

My legislation would do three things. One, in providing more leeway to the veterans hospital, it would establish a special priority category for those veterans who have Alzheimer's disease and related disorders, to lower the eligibility age for eligibility to the veterans hospitals to 50 years of age, and finally, it would require the Veterans' Administration to provide comprehensive counseling and treatment and information to those veterans with Alzheimer's disease.

Again, I think the purpose of my legislation is to provide a focus on this problem as I know it. Mrs. Paige is one of many throughout this country who is experiencing a similar situation in trying to admit their spouses to veterans' hospitals.

I am not wedded to the language in my legislation. Again, there have been those who suggested perhaps instead we should have set aside a percentage of beds in veterans hospitals for those veterans afflicted with such a disease. But, nevertheless, I think it is essential for the committee to address this issue because the incidence of Alzheimer's is only going to increase over time, not only because the veterans' population is going to double, the aging veteran population, but also the overall elderly population in this country will double in the next 40 years.

Finally, there is another aspect to this issue that I am also attempting to address, and that is the availability of trained personnel. In fact, I have introduced legislation that would require the Commissioner on Aging to set aside priority grants for those students who indicate they will specialize in the custodial or skilled care of Alzheimer's victims. In fact, this language has been incorporated in the Older Americans Act that is scheduled for consideration this month on the floor of the House. It is also included in the Senate legislation of the Older Americans Act and has already passed the U. S. Senate.

So again, Mr. Chairman, and members of the committee, I do think this kind of legislation is essential. Again, if we have trained personnel in the next few years, that would suggest that veterans' hospitals, adult day care centers, as well as home health agencies and nursing homes will have the availability and a pool of trained personnel that are necessary to provide the kind of treatment that is required of those victims who have Alzheimer's disease.

So again, I want to express my appreciation to the committee for giving me this opportunity to testify, to express my concern over this particular dilemma for those individuals who have Alzheimer's disease.

I thank the Chairman.

[The statement of Hon. Olympia Snowe appears at p. 55.]

Mr. **Edgar**. Thank you very much for your testimony.

Let me yield to my colleagues first for their questions. Mr. Hammerschmidt.

Mr. **Hammerschmidt**. Mr. Chairman, I don't have any questions, but I do want to thank Olympia for the very excellent testimony she brought to us this morning.

Mrs. **Snowe**. I thank you.

Mr. **Edgar**. Mr. Penny?

Mr. **Penny**. I have no questions, thank you.

Mr. **Edgar**. Mr. Hillis?

Mr. **Hillis**. I appreciate your testimony very much this morning. As we were speaking before the hearing, of course, I think this is one of several areas that affect aging where the Veterans' Administration should take a very special look at and perhaps give high priority to it. But there are several things that affect aging people. Diabetes, for example, and cancer has a higher incidence among the elderly.

Do you feel that we should spotlight just one condition, or should it be more our obligation to adopt an evenhanded approach toward all of these things that have a higher incidence with people considered to be senior citizens?

Mrs. **Snowe**. Well, again, I think we have to be responsive to the needs of the veterans, and based on the statistics that I mentioned, we are going to see a high incidence of Alzheimer's disease as we have already. Again, it is just being identifiable. For many years it was misdiagnosed by doctors as well. It was just considered to be senility.

On the other hand, I do think the Veterans' Administration would be better served if they could establish a more flexible policy. Again, maybe my language isn't the best language. I don't know and would certainly leave that up to the committee. The veterans' hospitals should have more flexibility in admitting those veterans that have Alzheimer's disease who may not be service connected.

Now, there may be some veterans who would be service connected because they have another disability and also happen to have Alzheimer's disease. But I do think it is unfortunate, as in the case of Mrs. Paige, for example, whose husband served for 25 years and does not have any money—whatever she has is in the form of life insurance. She will have to sell those policies in order to meet the financial obligations of putting her husband in a nursing home. Ultimately, that is what is going to happen. Then she will end up being indigent and then, of course, she will be eligible for medicaid. I think that's a sorry state of affairs. So if, perhaps, there is a better way of establishing the needed flexibility, so that we just don't limit care to only those found only under the present categories—and I do know now there are several categories for admission to the veterans' hospital that give preference to veterans in those categories. But again, I just think it is an issue that needs to be addressed because it is only going to get worse over time.

Mr. **Hillis**. I think you make a very convincing argument there, for two or three reasons. First as to Alzheimer's disease, I guess, we don't have the history of knowledge of it as we do for diabetes. Even though I think insulin was discovered in the 1920's, the disease was known for a hundred years or longer. Alzheimer's disease I think was named for the person who discovered it at about that time, but really nothing has been done until just very recent times.

Second, another point that impressed me that you just made is the fact that sometimes, like diabetes, Alzheimer's disease is a long-range affair, but it is hard to establish it as being service connected. A person may be suffering with it, but the symptoms don't show until many years later.

Third, it is something, that if the Veterans' Administration can work with the aging veteran who suffers from it, the general population will receive a big health dividend. We have seen other examples of that in the veterans' medical area and I think we really should take a hard look and try to find out as much information about care and a cure as we possibly can.

I certainly am happy to have you here this morning and to support your legislation.

Mrs. **Snowe**. I appreciate the gentleman's remarks. I would emphasize that some veterans' hospitals have been very responsive, like Togus, but some have admitted veterans with Alzheimer's disease and some have not. I can't explain the difference. I guess it depends on the availability of resources or beds or whatever the case may be. But the long-term care I think is going to be a major dilemma that will face this country in all respects concerning Alzheimer's disease. You're right, it is a long-term, debilitating disease and is very difficult for families to manage. I have met many who are taking care of their relatives who have Alzheimer's and it is a very difficult ordeal, to say the least.

Mr. **Edgar**. Dr. Rowland?

Dr. **Rowland**. No questions.

Mr. **Edgar**. Mike?

Mr. **Bilirakis**. Thank you, Mr. Chairman.

I have an opening statement, sir, that I would like to have inserted in the record.

Mr. **Edgar**. Without objection, your opening statement will be made a part of the record.

[The statement of Hon. Michael Bilirakis follows:]

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

I, too, want to commend you for calling this hearing and your continued efforts to examine the needs of a most vulnerable segment of society—our elderly veterans.

I, first, want to mention that I have a special interest in today's hearing, not only because I represent a district that is heavily populated by older Americans—many of whom are veterans—but also because we are addressing a matter that has become a focal issue of all our society, that of health care. I said I have a special interest in today's hearing as I know that some of our witnesses will address the problem of Alzheimer's disease. And, I am pleased to note that one of our witnesses is our Colleague, Congresswoman Snowe, who has introduced legislation that directly relates to Alzheimer's disease and the veteran population—legislation that I have proudly cosponsored. Hopefully our efforts will bring about some sort of positive action for the veterans that are suffering from this horrible disease.

We all realize that the population of older Americans is growing each day, as is the lifespan of the average person. As we continue to grow older, we must also learn hope to deal with the problems that come with age. Hopefully, hearings like this will enlighten us on the actions that must be taken. I want to thank our witnesses that have come to testify and look forward to hearing their testimonies.

Mr. **Bilirakis**. I would say to our colleague, Congresswoman Snowe, and this panel, that within the last couple of weeks the Select Committee on Aging held a hearing in my district in Bal Harbor, FL devoted solely to this matter. There are some pretty terrible and profound stories that come from the grassroots on what is happening to many families.

Congressman Hillis certainly raised a very good point, should we concentrate on Alzheimer's? I don't know that we should, but I think we certainly should take into consideration Alzheimer's disease and diabetes and some of these other conditions that seem to strike the older veteran, in many cases well before they reach age 65. Obviously, there is a limitation on facilities, as you know better than the rest of us, Mr. Chairman. Maybe we have to put more emphasis on these outpatient clinics such as the one needed in northwest Pasco County, FL and some of these other locations and make room for some of these older veterans. We have got to treat veterans in a different category than we do the regular older American population. I think they have earned much more. I am very proud of Olympia for having introduced that bill, and I am very proud to have cosponsored it.

Thank you, sir.

Mr. **Edgar**. Olympia, I have a couple of questions that I need to ask.

First of all, relating to the statement that you have added to your statement, without objection, the statement of Mrs. Paige will be included in the record.

Let's talk for just a moment about Mr. Paige. He spent 25 years in the military. He now has contracted Alzheimer's disease. Your statement and the statement of Mrs. Paige indicates the fact that the VA should now take responsibility for that particular individual.

I wonder what your feeling is about the responsibility of the military for this individual and whether or not military hospitals and military health care for retirees ought to have some role in providing the funding for caring for this particular individual who not only gave time to his country, as many veterans do, but as a member of the armed service, gave extended service to his country.

Mrs. **Snowe**. I would agree with the chairman. I think Mr. Paige's situation illustrates a very excellent example of where I think the military has failed to provide that kind of care as well. On the one hand, he can't get into a veterans' hospital—although in this case Togus has admitted him for various 2-week intervals for respite care—and on the other hand, the military does not provide for nursing home care, which was an interesting insight for me but which I did not realize before. The fact is even Togus would provide for nursing home care up to 6 months.

So I think the military does have an obligation and a responsibility, and again, that perhaps could be another aspect to the legislation. I think this example of Mr. Paige certainly underscores the point, which is the failure of the Federal Government to meet their obligations to those who have served in the armed services.

Mr. **Edgar**. It is my guess that the veterans' hospital probably bills the military for the care of Mr. Paige when he is admitted into the VA hospital. Do you know if—

Mrs. **Snowe**. That's a good question. I really don't know. Mrs. Paige has not told me that. Probably that is the case.

Togus has been very good about Mr. Paige. In fact, he has been there longer than they generally allow. The fact is Togus may be the only facility that has respite care of any sort. So it has been helpful.

Again, Mrs. Paige has indicated she will be selling her life insurance because at some point he has to be placed in a nursing home and there is no alternative for her. Until she depletes her own resources, she then can become eligible for Medicaid.

Mr. **Edgar**. One of the things we have tried to do with the VA health care system over many, many years is to not relate care specifically to a disease unless that disease is service-connected. I mean, there is a flurry of activity around Agent Orange, a flurry of activity around atomic veterans, because of the service connection of those diseases. In the case of Alzheimer's disease, it is much more difficult to see a link in terms of service connected.

What we have tried to do, at least over the last few years, in this committee, led by efforts to put in place the Geriatric Research Center, is to shift the VA's focus, give them some funds and resources and some staff, perhaps not adequately, to deal with the issue of aging, to hold hearings around the country to come up with some alternative health care modalities for caring for aging. You mentioned the issue of respite care, giving some time to the family who is caring for the veteran in their own home.

I guess I have one concern, which you might want to reflect on. Suppose we said, blanketly, any veteran of any war, of any service, who comes down with a diagnosis of Alzheimer's disease, will get care within the veterans' hospital system—and that is the aim of your legislation, I think—what does that really mean to the VA? What are we saying we're going to provide to that veteran? Are we going to provide them 100 percent full Federal funding, extended care, acute care, respite care, hospice care? What does it really mean for us to make that statement and what kind of impact does that have on our system? It's a tough dilemma.

Mrs. **Snowe**. It is, because of the numbers. There is no question that there would be an impact if we required the veterans' hospitals nationwide to have responsibility for the care of those veterans, service connected or not, who have Alzheimer's disease. But on the other hand, what is the alternative? Again, I think we do have to meet that responsibility.

Then there could also be the question as to whether or not it didn't begin during their time of service. In this case, as Mrs. Paige has indicated—and this is true in many instances of individuals who have Alzheimer's disease—they have had it long before it has been diagnosed. It gets progressively worse, but the early symptoms are not easily detected.

Mr. **Edgar**. As a liberal, I would say national health insurance is an option, catastrophic health insurance is an option, gearing the whole of our insurance program that we presently have in place to reflect the aging population generally, giving some focus to Alzheimer's disease, getting the VA geared up in terms of its geriatric research to look at some cures and solutions to this illness, maybe taking some specific pieces of the Alzheimer's question and not only researching them well but providing those pieces care within the system.

I'm just not sure, with $180 to $200 billion deficits in the foreseeable future, that we could go to any administration or any Office of Management and Budget and request a doubling of all of the resources in all categories of health care at this point in history.

Mrs. **Snowe**. From my own experience in encountering many individuals who are taking care of victims of Alzheimer's disease, it is a very dreadful disease because it takes its toll on the victim and also the victim's family. But again, we're going to have to meet that obligation at some point. I think we do have an obligation to provide assistance of some sort to the families.

For example, there are many families who are willing to take care of their relatives. In fact, I know many in my own State who are taking care of them at home. But they need some relief through home health care, for example. The fact is, I have introduced legislation to provide tax deductions for home health care for Alzheimer's disease. But I think we're going to have to——

Mr. **Edgar**. If the gentlewoman would yield——

Mrs. **Snowe**. Yes.

Mr. **Edgar** [continuing]. That is the kind of thing that we're looking at in this committee, the opportunity, for example, to use community nursing services and home health services and give respite care to families who do take that responsibility, and figure out ways the VA's health network can be helpful. There is a lot of teaching that can go on, teaching families on how to care for particular individuals in their homes.

Following your testimony today will be a number of witnesses who will talk about what the VA is doing in the whole question of geriatric and aging research, and also what they are doing in terms of providing specific kinds of care. We are very interested in having them be as innovative as possible.

The only reason for my question is not to say that we ought not to respond to this issue. I believe we should. The question is, how do we best respond without either building lots of nursing homes and extended home facilities, or, on the other hand, simply turning our back and turning off any kind of options through the VA. You stimulate for us a whole series of questions that we need to begin to ask of the VA and some of the people in the field who are spending time dealing with this issue. So I want to commend you for your statement.

Mrs. **Snowe**. I appreciate that, Mr. Chairman. I recognize the committee is much more familiar with the network within the Veterans' Administration and its own policies, and you probably could best address how we could facilitate in providing that care to veterans who have Alzheimer's disease. It is a mammoth problem overall for this country, and I do know from those individuals who care for Alzheimer's victims that they need some sort of respite and relief. So that is what I am seeking to address overall. It is going to take many forms, there is no question about it.

So often Alzheimer's victims need custodial care, and also they need a certain kind of environment. The fact is that many Alzheimer victims wander miles per week in their home. In fact, I know of cases where the individual will leave the home and they have to go searching for that individual. So it needs a certain kind of care and experience. That is what I am seeking to address in this forum, and there are many other forums in which we can address the concerns of those families who have Alzheimer's victims.

Mr. **Edgar**. Thank you.

Are there any additional questions? Thank you very much for your testimony.

Mrs. **Snowe**. I thank the chairman and the committee.

Mr. **Edgar**. Our next witness will be Dr. John Gronvall, who is the Acting Chief Medical Director of the Veterans' Administration. Dr. Gronvall, we welcome you here, and I will let you introduce your colleagues who will join you at the table.

Dr. Gronvall, without objection, your full statement will be made a part of the record. If you will introduce the two people who accompany you and proceed.

STATEMENT OF JOHN A. GRONVALL, M.D., ACTING CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY HOLLIS G. BOREN, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH AND DEVELOPMENT; AND JOHN H. MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE, VETERANS' ADMINISTRATION

Dr. GRONVALL. Thank you very much, Mr. Chairman. It is a very great pleasure for us to be here at this third hearing on the VA research program. I am accompanied here at the table by Dr. Hollis Boren, on my left, who is Assistant Chief Medical Director for Research, and Dr. John Mather, on my right, Assistant Chief Medical Director for Geriatrics and extended care in the VA Central Office.

Mr. Chairman, we will today present the work going on in a number of our medical centers having to do with aging. I will make only very brief comments because we want the work to speak for itself. I want only to say, by way of introduction, that we are attempting to change many people's attitudes about aging, which is usually referred to as a problem, and view aging as the natural outcome of, in fact, a great success story in this country. Some 30 years have been added to the life expectancy of American citizens since the turn of the century. As a result we now have before us a new set of problems that relate particularly to the aging process.

The fact is, of course, that most people are arriving at age 65 in good health. There have been recent surveys, for example, of medicare beneficiaries that have pointed out two-thirds of them describe their own health as excellent or good.

Naturally, as a part of the aging process, functional ability does decline, but in the absence of disease, the period of aging can be one of health and sustained functional ability.

In the cases where this is not the fact, there are a number of diseases that particularly are characterized by high incidence among aged individuals. They are well known—heart disease, cancer, stroke, the degenerative joint diseases, hearing and vision impairment, et cetera.

The Veterans' Administration has focused its research activities into three categories that relate to aging. First we are undertaking studies of the aging process itself, so that we can better understand what is going on with aging. Second, we are searching for alternative forms of care, to provide care and support to aging individuals. And then third, we are looking for specific improved treatments of the very specific problems that particularly affect aging individuals.

In your opening comments you have given the data that describe the problems that the Veterans' Administration will face in the near future, and so this aging research effort is a natural outgrowth of our look ahead to the large population of aged veterans who will be turning to us for care.

The last comment I would make is that our activities in the VA have been particularly crystalized by the geratric research, education and clinical center program, or the GRECC program. By the year 1985 we will have 10 GRECC's in operation, with their balanced program of research, education, and patient care.

Mr. **Edgar**. Would the gentleman yield on that comment?

Dr. **Gronvall**. Yes.

Mr. **Edgar**. What are your plans for the other five?

Dr. **Gronvall**. We have authorization, as you pointed out, for 15. We will have 10 in operation. We have developed plans looking at the geography of the country to develop GRECC's on a geographically distributed basis to accomplish the full 15 spread throughout the country.

Mr. **Edgar**. Do you have a timeframe on that?

Dr. **Gronvall**. Perhaps it would be well for me to turn to Dr. Mather, who has direct responsibility for this program.

Mr. **Edgar**. OK. We will get back to that. I didn't mean to interrupt your statement, but I thought at that point, when you were talking about the 10 being put in place at present, that it would be helpful for the record to show what the plans are for the additional 5. We will come back to that issue.

Dr. **Gronvall**. OK. Thank you.

The last thing I wanted to point out is our geriatric evaluation unit program. We currently have some 26 operational geriatric evaluation units and we are planning 15 others. These have been particularly helpful for our multidisciplinary teams in our medical centers to evaluate each patient, create a treatment plan, a plan of assisting the person to improve function, and retain health, and we will present the results which have shown that this is a very highly desirable way of dealing with some of the special problems of aging. We have these activities throughout our system. We have created a strong focus on the problems of aging.

Again, in summary, it is a delight to be here to present selected examples of this work, and I would turn to Dr. Hollis Boren who will introduce our witnesses today.

Thank you.

[The statement of Dr. John Gronvall appears at p. 63.]

Mr. **Edgar**. Before we go to the additional witnesses, there are a couple of general questions that I think some of our members may want to ask, if this would be the appropriate time before we move to witnesses.

Dr. **Gronvall**. Fine.

Mr. **Edgar**. The first question I have relates to the VA's attempt to put together an aging plan, that is, an overall plan for the VA and its hospitals and health care institutions, to respond to the aging.

After a preliminary draft of that plan was put together, somewhere in the process it had been translated into a report and not a plan, and then someplace in the process it has disappeared. I wondered if you could clarify whether or not it is a plan, or whether it is a report, or whether it is a memo, and where it might be.

Dr. **Gronvall**. Mr. Chairman, I can try to clarify it briefly. We are describing it as a report. You are quite correct, that its publication has been delayed. It has been delayed, really, for two reasons. One is a final editing process that has gone on, and the other is that for purposes of comparison, we wanted to incorporate in the report the data that were prepared and presented in the Congressional Budget Office study which was recently released.

The aging report is now in the final stages of executive branch review.

Mr. **Edgar**. Do you have any idea when this committee could anticipate holding oversight hearings on the specific recommendations in that report?

Dr. **Gronvall**. As I said, it is in what I understand to be the final stages of executive branch review. I can't really predict with any assurance when that will be completed so that the report would be available for hearings.

Mr. **Edgar**. Would it be correct to characterize it as an "aging" aging report? [Laughter.]

Dr. **Gronvall**. Mr. Chairman, I would never disagree with the chairman of this subcommittee.

Mr. **Edgar**. Let me ask you another general question. This is asked on behalf of Mr. Penny.

The Senate has cleared a provision in the Older Americans Act which would provide for coordination between the VA and other Federal agencies on the aging problem. Does the VA have any position on this provision in the Older Americans Act, and what degree and kind of coordination already exists?

Dr. **Gronvall**. In regard to the first specific question, frankly, I am unaware of that specific provision. To my knowledge, we have not been asked to respond to it. I may just not have the information on that.

But we do have active mechanisms in place for the coordination of aging research. We are participants on an interagency committee on research on aging. That committee is under the sponsorship of the National Institute on Aging. A member of the VA staff, in fact, serves as cochairman of that committee. It is a large committee on which there are represented 28 different Federal agencies and offices that are involved in one way or another in aging research.

The committee meets at least three times a year in formal session. It serves as a coordinating device, clearinghouse, to ensure exactly what you're inquiring about, namely, that the entire Federal effort that relates to aging will be coordinated and so that the various agencies will be informed of what's going on.

I would say that beyond the formal committee itself there are many informal regular communications back and forth among the agencies involved in research.

Perhaps Dr. Mather could comment on the specific provision you referred to in the Older Americans Act.

Dr. **Mather**. Mr. Chairman, we testified before the Senate Committee last year on the initial draft of the Older Americans Act before Senator Grassley. At that time we indicated in considerable testimony the extent to which we do coordinate already the VA medical centers with the area agencies on aging and the State units on aging, which are really the subject of the Older Americans Act.

We have already in place an extensive information and referral program that has been the subject of an interagency agreement which has been in existence for about 5 or 6 years. We haven't seen the final version of the Older Americans Act, but the provision you refer to would seem to be something which we are doing already and would extend further.

We do know that at least 25 percent of our VA medical centers have very strong associations with the Triple A's at this point in time and are already engaging in cooperative activities.

Mr. **Edgar**. Thank you.

Let me ask you a couple of additional questions.

Dr. Gronvall, in your testimony you stated that Geriatric Evaluation Units reduce deaths and produce fewer placements in nursing homes or hospitals. To what do you attribute these results?

Dr. **Gronvall**. In a general way, I think we attribute the results to the fact that whenever a team of well-informed professionals make a careful evaluation of an individual patient, and then prepare a treatment plan or a plan of support, the quality of both the diagnosis, the plan of action, and the support system is enhanced. So it is a more focused attention on the whole array of problems that affect any individual patient, rather than a focus only on one specific disease entity. The outgrowth of having an entire team of multidisciplined specialists is that the other elements of the patient's problem are not overlooked.

Dr. Mather, I don't know if you would want to add anything to that comment.

Mr. **Edgar**. Let me ask a followup question to that before Dr. Mather speaks.

If these units saved lives and costs, how long should we wait before we insist that every VA medical center have such a unit?

Dr. **Gronvall**. I think that is a very difficult question to answer. We have, as I said, a number of the units in operation and are planning for the implementation of others.

Dr. Mather, you might want to expand a little on the planning and the timetable for such units.

Dr. **Mather**. Mr. Chairman, I know Dr. Abrass will talk about this later on, but I would like to add a couple of comments myself.

I think we have seen very clearly, where these geriatric evaluation units are in place, the systematic geriatric assessment that takes place covers not just their medical condition, per se, but their ability to function, and also to look at the socio-economic support systems for that individual. So that intensive, comprehensive assessment leads to natural conclusions about better placement and, in fact, to placing them at a more appropriate level of care. It is that intensive multidisciplinary approach which brings that about.

We have made it a matter of prime concern during the past 18 months to further develop geriatric evaluation units. We have done it within existing resources and have twice during the past year sent forth within the system requests for the establishment of such units. We have further secured the assistance of a couple of consultants who are in the process of going around and assisting in the further development and establishment of these units.

We don't think at this point in time, though, that there is really sufficient evidence to mandate it throughout the whole system. I think there are differences between hospitals and we need to discern those differences before one makes such a mandate to the system.

Mr. **Edgar**. Can you tell me why the geriatric evaluation unit at the West Haven VA Medical Center was closed recently?

Dr. **Mather**. Mr. Chairman, I don't know the exact answer to the question, but I know that they had some problems with staffing. We have been looking at a recent proposal that they have sent in to further establish and get that back on track.

Dr. **Gronvall**. We would be happy to follow up and supply additional comment for the record on that.

Mr. **Edgar**. Without objection, it would be helpful to have that as part of the record.

[Subsequently, the Veterans' Administration furnished the following information:]

The Geriatric Evaluation Unit (GEU) at West haven VAMC, which was activated in September 1983, was not closed recently. However, during the first few weeks in June no new patients were admitted because the unit was preparing for a move to a different location in the hospital. The operation of the GEU returned to normal on June 18, 1984.

Mr. **Edgar**. Can you also give me an idea of how many specific research projects on aging are now being conducted by the VA this year?

Dr. **Gronvall**. I think I would like to turn to Dr. Boren, who could probably best respond to that question.

Dr. **Boren**. We have some 330 to 340 projects for which, in the evaluation of the principal investigator, aging is either the primary or secondary concern. This amounts to almost $10 million of our budget going to these targeted areas.

Mr. **Edgar**. If, as we described in the opening statement and others, the prospect of doubling and tripling the numbers of people who are aging veterans, and if, as was discussed in terms of the last century, we have raised the number of years by some 30 years the average life expectancy, are these funds for research adequate as we move into the late 1980's and 1990's to provide quality research in the area of aging, particularly as it relates to aging veterans?

Dr. **Boren**. No, I think it would require increased resources.

Mr. **Edgar**. Will that be at all spelled out in the "aging" aging report?

Dr. **Boren**. Yes, sir, I believe it will.

Mr. **Edgar**. Thank you.

Mr. **Bilirakis**. Would the chairman yield a moment?

Mr. **Edgar**. I yield to the gentleman.

Mr. **Bilirakis**. Doctor, research, particularly on this subject, and certainly all subjects, is taking place across this country. One of the things we addressed in our hearings down in Florida recently was the possible need of some sort of a central clearing-house, if you will, on research, so that each group can take advantage of the research that has taken place elsewhere.

Is the VA involved in that, or is the VA doing independent research basically on its own, almost regardless of what may be taking place in other sectors?

Dr. **Boren**. This is what Dr. Mather had reference to on the National Institute of Aging. Our investigators successfully compete for support there, and there is coordination of the projects between the National Institute of Aging and ourselves, sir.

Mr. **Bilirakis**. Now, is the National Institute of Aging sort of serving as a research clearing house? Are you satisfied that it is doing that adequately?

Dr. **Gronvall**. Yes. I would like to ask Dr. Mather to comment on that.

Dr. **Mather**. Congressman, I sit on the National Advisory Council on Aging of the NIA representing the Veterans' Administration in an ex officio capacity, so I am privy to and, in fact, held responsible for coordinating some of the work and disseminating the information on what research is going on.

We also make a major contribution each year to the inventory of all research being done on aging. The complementary nature of the research that is going on between the agencies becomes very clear. Part of the aspect of research that I think will always end up in some people's eyes as being duplicated is that research in a particular laboratory has the same focus as the research in another laboratory. But there is some serendipity there as to which one, in fact, is going to be able to achieve the answers to the research on the questions being posed.

Mr. **Bilirakis**. Thank you, gentlemen.

Thank you, Mr. Chairman.

Mr. **Edgar**. Dr. Mather, your use of the word "laboratory," I hope you use it a couple of times today because I like the way it sounds coming off of your tongue.

Dr. Gronvall, do you want to continue?

Dr. **Gronvall**. You had asked us some questions about our plans for expansion of the GRECC's, and perhaps with that amount of prompting, I could encourage Dr. Mather to describe some of the laboratory work going on in the GRECC program and respond to your earlier question on plans for expansion of additional GRECC's.

Dr. **Mather**. Mr. Chairman, as I know you are aware, the Geriatrics and Gerontology Advisory Committee did provide its report last year with its assessment of the GRECC's, and I think it brought out very clearly for us the need to pursue the establishment very quickly of two additional GRECC's. As you have heard, those will be fully operational in this coming fiscal year.

We have looked at the country, as required by the law, as to the appropriate geographic distribution of GRECC's, and we do know at least of two additional areas that would be best served by having GRECC's in the not too distant future. The first one I think we would have to identify as the inter-mountain area and down into Texas. When you look at a map of the distribution of the GRECC's, that is very clearly a place where there ought to be an additional GRECC.

I think one would have to say, though, that it is clear from the prototype staffing for a GRECC that the establishment of additional GRECC's is subject to the availability of additional resources to get them underway.

Mr. **Edgar**. Do you have a list of criteria as to other things, other than just geographic distribution? Are you looking for areas that have medical schools, teaching facilities, other resources in the community, where you might be able to have affiliations with other aging research centers?

Dr. **Mather**. Yes, Mr. Chairman. And as you know, within the law it really spells out those minimum criteria that we have to have. In fact, in the solicitation package that we sent out last year to some 10 or so facilities in the Southeast, all those were carefully spelled out, and the way in which we would evaluate the proposals that came in were in relationship to those kinds of criteria that you are alluding to.

Mr. **Edgar**. Do you have any number as to how many applications you have from the VA centers around the country for the establishment of GRECC's, how many areas are in competition for the two or the additional five?

Dr. **Mather**. We did the specific solicitation to the Southeast last year and we asked for letters of intent from about 15 facilities. After that, in fact, only 11 chose to pursue sending in a full proposal. Out of that, with the funding available, we did establish at half funding two new GRECC's at the VA medical centers in Durham and Gainsville, which will be annualized during this coming year to full GRECC's in fiscal year 1985.

In response to your question relating to other facilities that have expressed an interest, we know now that about 20 have had telephone inquiries to my office as to what the status is. Most of those have asked for a copy of a blank proposal that they can look over, so when they get the opportunity to respond, given the geographic requirement, they would be better prepared.

Mr. **Edgar**. Thank you very much.

Dr. **Gronvall**. With that, let me then turn to Dr. Hollis Boren to introduce our additional witnesses.

Dr. **Boren**. Mr. Chairman, thank you for the opportunity of being here this morning.

First of all, I would like to introduce Dr. Marguerite Kay, who is the associate chief of staff for research at the VA Medical Center in Temple, TX. Dr. Kay is also one of this year's Fleming Award winners.

Dr. Kay will speak to us on the immunology of aging.

STATEMENT OF MARGUERITE M.B. KAY, M.D., ASSOCIATE CHIEF OF STAFF FOR RESEARCH, VETERANS' ADMINISTRATION MEDICAL CENTER, TEMPLE, TX

Dr. **Kay**. Mr. Chairman and members of the committee, I am pleased to have the opportunity to discuss some of the aging research that the Veterans' Administration is doing with you today. My name is Marguerite Kay, and I am associate chief of staff at the Veterans' Administration Medical Center in Temple, TX.

The research that I am going to discuss is going to be more of the basic research upon which eventually the clinical decisions for treatment will be made. Bear with me and stop me if I use any terms that are a bit esoteric or too much jargon.

I am sure that you know by now that the 65 and older population is the most rapidly growing segment of the U.S. population. I will just show you a few demographics to underline the point. For example, by the year 2000, two-thirds of the men over 65 will be military veterans. This obviously is going to present a crisis, financially and personally, for individuals.

There are several approaches to the coming crisis in aging in this country. One approach, which is in a way the easiest and which we use because we don't really know what else to do, is to make use of long-term care facilities and put people into nursing homes rather than attempting to treat their diseases. This is extremely expensive, both in terms of dollars and quality of life, to the individual.

It is estimated right now that we will need 50 percent more nursing home beds by the year 1990, and I suspect that that's a conservative estimate. The approach of those who, like myself, are interested in basic research is to view aging as a natural process that is separate from disease. It is all too easy to feel that disease is part of aging because we see an increase in disease in the older population. This is not necessarily the case. So the view of people such as myself and those basic science researchers in the VA is to look at basic causes, basic mechanisms, for both aging and disease in order to separate the two. Obviously, if we can treat diseases associated with aging and stop the disabilities, then we can increase the productive life span. Our goal here is not to increase actual longevity. There is, in fact, a maximum life span for human beings. But I think most of us can agree that we would rather die at the age of 70 on a tennis court than after 10 years lying in a bed in a nursing home. I doubt that anyone will dispute that. I think that that is a definite possibility.

Medicine has, by and large, treated symptoms rather than curing disease. This is in part because we have not had the technology available that would allow us to actually treat diseases. We have tremendous diagnostic tools that help us. We're just so good at diagnosing things that we simply cannot treat. However, there has been a major revolution, as I am sure all of you know, in technology that is just truly astounding. We have never had such an opportunity before in this country. With the high tech and genetic engineering we actually have the possibility now to cure disease if we understand what causes it.

An example of our ability to diagnose and not treat lies in things like Alzheimer's and other diseases, where we can diagnose perfectly well but simply cannot treat. Actually, we can treat, we can manage the people, we can make them more comfortable, but we cannot cure disease.

The research into basic causes of aging has concentrated in many cases at the cellular level. Basically, we are trying to find primary causes of aging. Now, until quite recently, most of the aging research was purely descriptive, out here at the periphery, where you could describe changes, grey hair and things such as that. We are targeting primary causes here. If we know the basic molecular mechanism, that's where we can intervene. The forefront research in this area we hope is now in the secondary circle, with the next step taking us to the primary mechanisms which will give us the knowledge to treat. At worst, we are somewhere out here, but we are certainly much closer than we have been.

Research into primary mechanisms has indicated that there are changes at cell membranes. Now, obviously all interactions occur at the membrane, so that is a good place to look at changes in communication. Research to date indicates that there is a change in the proteins within the cell membrane. Don't try to memorize this.

I will not quiz you on it later. This is simply a scheme of some of the molecular changes that occur within a membrane, and you need not pay attention to specific names.

Basically, we have found that there is an aging protein that appears in membranes. It is shown up here. When this aging protein appears, it initiates removal of the cell. So the question is, what causes this aging protein. So we will go down here and look at this protein sitting very happily in a cell membrane, a normal cell. Then something happens, and that's our big grey question mark that we're working on now, as to what will happen. Then this protein is broken apart and exposed on the surface.

Now, one can say there are many things—perhaps oxygen, free radicals—where such things can damage this protein and terminate the life span of cells. We don't know the answers yet, but once we can control either this protein or the other proteins involved in removing the cell, we should be able to control, physiologically, the removal or the life span of cells.

The implications of this are quite obvious. In the case of neoplasia, we would hope to, without the use of chemicals, use the immune system of the individual to determine the cell's life, to remove the cancer cells. In contrast, if we wish to prolong the life span of cells, such as the life span of a neuron, we could do that. That is the ultimate payoff, making it worth the work and the risk.

Thank you for your attention.

[The statement of Dr. Marguerite Kay appears at p. 69.]

Mr. **Edgar**. Are there specific questions of Dr. Kay?

I have a question about the specific research you are doing with proteins and what transpires there. How are you getting at that issue? I mean, what is it that you're doing on a day-to-day basis to focus in on that issue, watch it, discover it? What are the parameters of the research that brought you to that last chart?

Dr. **Kay**. It is difficult to give a fairly condensed answer to it. Are you asking about the technical details, such as molecular biology, immunology?

Mr. **Edgar**. I guess I'm really asking you more what is it that you are doing, what is your research grant, what area of research? Are you doing rats, are you doing snakes, are you doing——

Dr. **Kay**. Oh, humans, of course.

Mr. **Edgar**. Are you doing it in a hospital laboratory setting? Just a descriptive——

Dr. **Kay**. OK, fine. I am in a fairly unusual situation, where I sit in a Texas A&M University building on VA grounds. It happens the research facilities are leased to Texas A&M, which maintains it.

My research is done with humans predominantly, although we have confirmed the data using germ-free mice, to make sure that we are not getting a viral contribution to it. The primary model has been the red blood cell because it has a clearly defined lifespan. We can get large numbers and separate them easily. But we have confirmed our findings. Once we work out the hard part on red cells, then we turn around and it is very simple to check other cells. We have confirmed our findings on neurons, kidney cells, liver cells. Just start naming cells and all of them we have looked at and have confirmed our findings on.

The set up that I have is academic, where I train graduate students and post-doctorate students in this area of research.

Mr. **Edgar**. Are you working then, once you discover the broken protein, to figure out either biological or physiological ways to care for that protein so it doesn't break apart?

Dr. **Kay**. That's where we are now. We have definitely identified the protein. We have confirmed what it's origin is. We are now up to sequencing this protein so that we will be able to synthesize it. In addition, we are down to the point where the only thing that is lacking—we think the only piece of the puzzle lacking—is what the actual initial damage is, whether we're getting a cross-linking with age due to free radicals and such things. Once we have that—and we are also setting up a system where we hopefully will have protein that is immortal and doesn't age. So that our goal is, once we know what causes it to age, we will know then how to stop it from aging.

Mr. **Edgar**. How do you talk with other researchers across the country who are doing exactly the same kinds of research or similar?

Dr. **Kay**. Usually at conferences—Well, No. 1, we communicate by publishing papers. Then we will talk to each other at conferences, or somebody will read your paper and write you a letter or get on the telephone. So there is a fair amount of phone calls and talking at meetings and such things.

Mr. **Edgar**. I would like to ask Dr. Rowland to take the chair for about 10 minutes while I run an errand. I want to thank you for coming this distance and sharing your information.

Dr. **Kay**. Thank you.

Dr. **Rowland** [presiding]. You may proceed.

Dr. **Boren**. The next witness is Dr. Jack Rowe, the Director of the GRECC at West Roxbury in Boston, who is going to speak on endocrine disorders such as diabetes mellitus in the aging veterans. Dr. Rowe.

STATEMENT OF JOHN W. ROWE, M.D., DIRECTOR, GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER, WEST ROXBURY/BROCKTON VA MEDICAL CENTER, BOSTON, MA.

Dr. **Rowe**. Good morning. Mr. Chairman and members of the committee, I am Jack Rowe, director of the GRECC at West Roxbury/Brockton in Massachusetts, and I am director of the division on aging at Harvard Medical School. I am devoted to the care of the elderly and I conduct clinical and laboratory research on changes in endocrine systems that occur with aging.

This research focuses on age changes in the production of hormones and their effects on various organs in the body. In this testimony I will comment on the impact of age-related endocrine changes and on the very well developed research program of the Veterans' Administration in this important aspect of geriatrics.

The endocrine glands of the body include, among others, the pancreas, pituitary, thyroid, parathyroid, and adrenal. Endocrine changes that occur with normal aging do not represent diseases, but they do decrease the capacity of the elderly individuals to respond to stress, such as surgery or acute illness, thus increasing their risk of complication. In addition, endocrine diseases are more common and often more severe in the elderly. Endocrine studies of aging are currently being performed in six of the eight GRECC's established by the VA throughout this country, as well as at numerous VA medical centers that do not have GRECC's. This reflects the commitment of the Veterans' Administration's Research Service to improving our understanding and the management of the burden of endocrine disease of our growing elderly population.

I would like to focus on the changes that occur in the pancreas with normal aging and to a pancreatic disease, diabetes mellitus, that is common in the elderly.

Older individuals are inefficient in using sugar as a source of energy. This results in higher blood sugar levels in the elderly than in their younger counterparts. Failure to take this normal high blood sugar of aging into account often results in an older individual being incorrectly diagnosed as diabetic when they actually may be normal for their age.

The possible causes of high blood sugar accompanying aging include alterations in diet or activity, obesity, deficiency of insulin, or the decreased activity of insulin on the target tissues. Studies performed at GRECC's in California and Massachusetts, as well as at the VA Medical Center in Denver, CO, indicate that resistance to the action of insulin in the peripheral tissues is the major component for the cause of high blood sugar in aging. This resistance to insulin's action is aggravated by obesity and lack of exercise with advancing age. These decreases in the capacity to handle sugar are normal for older individuals. When greater decreases are present, they indicate the presence of diabetes mellitus, the third leading cause of death in the United States and the leading cause of blindness. There are currently 5 million diabetics in the United States.

The number of diabetics increases dramatically with age. At age 40, 4 percent of individuals are diabetic; at age 65, 7 percent; by age 85, over 15 percent of individuals have diabetes.

As with many other diseases, the treatment of diabetes is importantly altered with advancing age so that expertise in geriatrics, such as is being developed by the GRECC's within the Veterans' Administration, is an important component to the proper management of elderly diabetics. Just as children do not merely represent young adults, older individuals do not represent just old adults, but have a different physiology and require different management of their diseases.

The Veterans' Administration has, in my view, taken the lead in developing academic research and educational programs in geriatrics in this country. As I say, I direct what I think is one of the largest, if not the largest, academic program outside the VA as well at Harvard Medical School, and I am familiar with academic geriatrics. It is clear to me that the VA has taken the lead in this area.

In the case of diabetes, to be specific, the VA has developed and supported a two-pronged approach in investigating not only the changes that occur with normal aging, but also the special characteristics of elderly diabetics. This two-pronged approach will improve our understanding of the aging process and its clinical impact.

This concludes my statement and I will be pleased to answer any questions.

Thank you.

[The statement of Dr. Jack Rowe appears at p. 74.]

Dr. **ROWLAND**. Thank you very much.

May I say at this point that I am very pleased with the amount of research that is going on in the VA, not only in diabetes but in all areas. I am very pleased with what the VA is doing.

I want to ask a question or two about the geriatric evaluation units that are in place. What is the mode of operation of these units and how do you determine who goes to these units for evaluation, and what disposition is made of the people that go to these units, just a very brief statement so I will have some idea about exactly how they function.

Dr. **GRONVALL**. One of our other witnesses, Dr. Abrass, actually will be making comments on the geriatric evaluation units. I think perhaps in his testimony and then as a followup to that we could deal with that in a comprehensive way.

Dr. **ROWLAND**. All right, that will be fine. We will just wait until he comes up.

Thank you very much, Dr. Rowe. I have no specific questions to ask about diabetes.

Mrs. Johnson?

Mrs. **JOHNSON**. I have no specific questions, either, but I am very interested in the implications of your research and of the preceding speaker for the population at large. As has happened in some other instances, the VA is able to focus on problems of enormous importance to our whole society. It is a pleasure to see that you're moving ahead.

Dr. **GRONVALL**. If I might, in addition to thanking you for that comment, I would like to just expand a little from my perspective.

I think that is one of the reasons why it is so important for VA researchers to be a part of the national and, in fact, international community of researchers. It is why we want the research work done in the VA to be published in national journals. Our investigators compete not only for funds within the VA but for funds in the National Institute of Health, et cetera, et cetera, because while we clearly have the specific areas of concentration in the VA research program that will most directly affect and improve the health of veterans, we want very much to have the results of our research benefit the entire population. So I appreciate very much your comment.

Dr. **ROWE**. If I could also comment, Mrs. Johnson, I have a lot of young investigators come to me looking for advice regarding careers in geriatrics. I speak with investigators around the country regularly. The advice that I give them at this point is to seek in many instances—in fact, in most—if it is possible for them, a career in the Veterans Administration. It is really clear that the VA has taken this seriously, so that the research support, although obviously we would like to have more, is available for young investigators.

In regular medical centers around the country, as Dr. Rowland knows very well, there is still a bias against aging. There is still ageism in those hospitals that you worked in and that I work in.

The Veterans' Administration, I think, is turning that around faster than the other sector.

Dr. **Rowland**. I think it is appropriate that they do turn it around, as was indicated earlier by the aging veterans population.

Mrs. Johnson?

Mrs. **Johnson**. I would like to also comment that I think the importance of Chairman Edgar's question to the preceding speaker reflects your concern, at least his question indicated that to me. Do you feel you have sufficient opportunity to communicate with researchers outside of the VA structure, both nationally and internationally? Part of his concern is a concern we all share, that is that if, indeed, you feel for some reason, either because of legal constraints or monetary constraints, you do not have sufficient rapport, stimulation, opportunity or whatever within that larger community, we would certainly want to know about it.

Dr. **Rowe**. I will never, obviously, in front of this committee or any other congressional committee, say there are not monetary restraints. There always are. But I think we have very adequate opportunity to collaborate and interact.

We are not isolated within the Veterans' Administration at all. In fact, our problem in aging now is that we have too many opportunities to communicate and too many meetings, et cetera, to choose from which we should go to. So I don't think that is a major problem for us.

Dr. **Gronvall**. One other brief comment that would be germane to that, that through the affiliation system the research workers in the Veterans' Administration and their colleagues in the academic medical centers and medical schools of the country have a very free and open interchange. Again, that contributes to the sense that the VA is, in fact, very much a part of the national and international community of researchers.

Dr. **Rowe**. One last point on this that relates importantly not only for the investigators—I think this is an important point that Mr. Edgar brought up—not only the investigators, but also the agencies. The Veterans' Administration is in very close contact and collaboration with the National Institute on Aging, so that they do not develop programs that are contrary to each other or in each other's way, but rather supplementary or complementary. I served for many years on the study section, and recently as chairman, of the Aging Institute study section that reviewed grants. There was a lot of Veterans' Administration investigations that were funded by NIH and very good communication between NIH and the VA in this regard. So I think that that is working very well on that level.

Dr. **Rowland**. Wouldn't you agree that there are some barriers, however, not just within the VA, but between all researchers, on the pride of discovery, where you protect what you are working on and you don't make all of the information available because you may lose some of the credit that you would have gotten otherwise?

Dr. **Rowe**. Yes.

Dr. **Rowland**. I just point that out, to say that that situation does exist.

Dr. **Rowe**. I think it certainly does. And while it has its good and bad points, there are ways to get around it. Last year we had a Gordon Conference on Aging, where investigators come and present data that is not yet published from their laboratory, for instance, so we could share there. There are ways to try to work around it, but it is a problem.

Dr. **Rowland**. Thank you very much, Dr. Rowe.

Dr. **Rowe**. Thank you.

Dr. **Boren**. Mr. Chairman, the next witness is Dr. Gabe Maletta, who is the director of the GRECC at Minneapolis, who is going to speak on the diagnosis of the dementias. Dr. Maletta.

STATEMENT OF GABE J. MALETTA, PH.D., M.D., DIRECTOR, GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER, VA MEDICAL CENTER, MINNEAPOLIS, MN

Dr. **Maletta**. Thank you very much, Mr. Chairman, and members of the committee. I am pleased to have the opportunity to discuss today the topic of diagnosis of dementia in the elderly.

My name is Gabe Maletta. My postgraduate training is in physiology, medicine, and psychiatry, and I am presently the director of the GRECC at the Minneapolis VA Medical Center. This is a GRECC that focuses on veterans with diseases of the aging nervous system.

I am also a faculty member in the Departments of Psychiatry and Neurology at the University of Minnesota Medical School, and I have been involved in the study of gerontology and geriatrics for more than 20 years. I have published in the area of the aging nervous system.

I sit on many committees, boards, and task forces that focus on aging from many directions. For example, I am a member of the national board of medical advisors of the Alzheimer's Disease and Related Disorders Association. I am also on the task force on psychiatric services to the elderly of the American Psychiatric Association.

The continuing increase in the percentage of the population of the United States over 65 is well known and I will not belabor the point here. I will say, however, the Veterans' Administration in some ways represents a forerunner of this overall "greying of America" since at the present time the numbers of veterans over 65 already number about 3.3 million, and by the turn of the century, as was stated, 16 years from now, the numbers will increase to a staggering 9.3 million veterans. This tripling reflects all those veterans from World War II and the Korean conflict who reach and surpass age 65 now and throughout the next several years.

Along with this increase in the number of elderly, there is a concomitant increase in the diseases which are more prevalent in this age group. The frequency of many diseases of the nervous system increase with aging. Many of these nervous system diseases are characterized by an intellectual decline and deterioration and are referred to as the dementias.

It is important to define properly the word "dementia" because of the large number of meaningless labels that are presently attached to people suffering from these kinds of diseases, and also because of the myths that surround them. For example, the words "senility, organicity, organic brain syndrome" are meaningless because they have no diagnostic specificity and, therefore, no effective treatment plan can be mounted.

One of the major myths surrounding elderly individuals with these diseases is the idea that intellectual deterioration is a normal development of the aging process, rather than an expression of nervous system disease as we understand it to be today. This can be seen clearly by the fact that although the numbers of elderly with dementing illnesses are very high, more than 2 million at the present time, with over half of these dementias caused by Alzheimer's disease, that is less than 10 percent of the total population over 65.

Because the dementias are more prevalent in elderly individuals, and due to the fact that this segment of the population is so rapidly expanding, there will continue to be a significant increase in patients with dementias over the next several decades. Therefore, it is critical to reinforce the fact that people with dementia are individuals suffering from diseases. It needs to be well understood that appropriate and effective treatment and, eventually, prevention may occur.

Let me define dementia for you, and it may be reviewed from the handout that is before you that I presented. Dementia is essentially an observed group of signs and symptoms characterized by a generalized deterioration in intellectual function that gradually takes place over a long period, sometimes years. For example, a decrease in paying attention, perceiving, concentrating, being oriented, memory, judgment, word finding and so on may all be seen in these patients. It is important to note again that dementia is not a disease at all but simply a group of signs and symptoms caused by a variety of different diseases.

I would like to make three quick points during the course of this brief presentation. No. 1, the dementias, as I just defined them, are caused by a variety of diverse neurological and medical problems. Again, please refer to your handout entitled "Major Causes of Dementia." No. 2, dementias are not simply a medical problem but must be considered as a multifaceted one or a multidimensional one, involving the so-called bio-psycho-social-cultural approach. The third point is that all presentations of unusual intellectual function or behavior in an elderly individual are not necessarily dementia. Let me elaborate briefly on each point, if I may.

Point No. 1. Dementias are caused by a variety of medical and neurologic problems. On your handout, which lists a large number of causes of dementia, I would like you to focus on the first two—that is, Alzheimer's disease and multi-infarct dementia. Multi-infarct dementia simply means a series of many small strokes in an individual. Alzheimer's disease makes up approximately half of all dementias seen in the elderly, while multi-infarct dementia makes up 20 to 25 percent.

As you know, the cause of Alzheimer's disease is not yet clearly understood, although research continues at the present time, not only in terms of cause but also in terms of management. All the rest of the diseases on the list you have make up approximately the other 25 percent of the causes of dementia in the elderly.

It is important to point out that a dementing illness may be either progressive, static, or remitting. That is to say, over time the intellectual impairment of a patient with progressive dementia will get gradually worse. Another patient also suffering from dementia but with a different cause may remain at the same level of intellectual dysfunction for many years. This is the so-called static dementia. It doesn't get any worse and it doesn't get any better over the years.

The concept of remitting, the third type of dementia, is similar to that which is called reversible dementia by some of my colleagues. For example, an individual found to be suffering from a specific curable disease such as vitamin B-12 deficiency or chronic hypothyroidism which was causing a progressive dementia is treated. It is arrested or remitted at that point. The patient will get no worse and, in fact, may even get somewhat better. This is the concept of a remitting dementia.

A point to be reinforced is that even although all individuals with a dementing illness present a generalized deterioration of intellectual function, the cause of this deterioration varies widely from one patient to the other.

The second point is that the dementias as a group should not be considered as a medical problem but as a multifaceted one. Now that we are aware that a large number of causes for the dementias exist, it must also be pointed out that individuals with these diseases do not live in a medical vacuum. Their psychologic, socioeconomic and cultural situation must also be considered. A good example of this approach are the nutritional dementias. It is certainly possible to become demented over an extended period of time by depriving an elderly individual of a needed nutrient, such as vitamin B-12. However, that elderly individual may be unable, because of physical infirmities, to go out and buy food and, therefore, does not eat; or perhaps that individual may be too depressed to eat following the death of a spouse of 40 or 50 years several months earlier; or perhaps the individual does not have enough money to buy adequate food to eat; or perhaps he no longer smells, tastes or sees the food as well and food is therefore no longer important—and so on. The point is a simple one. When considering a medical problem such as the dementias, one must also consider the special psychologic, sociologic, economic and cultural problems that exist today with this elderly population which may precipitate or aggravate the disease.

The third and last point to make is that all presentations of unusual behavior in an elderly patient are not necessarily dementia. This involves a process known as differential diagnosis. In an elderly individual who presents unusual behavior, one must think not only of dementia but also of different diseases that may be present with similar signs and symptoms. For example, many of these other diseases are grouped under the term "delirium." These are diseases characterized by a rapid onset of symptoms. Again referring to your handouts, you will find a definition for delirium as well as a table of "Major Causes of Delirium."

Also, depression in an elderly individual may frequently be mistaken for a dementia. The reason for the misdiagnosis is that the presenting signs and symptoms may look similar in all these diseases. Often an elderly individual with a delirium may present with a generalized deterioration of intellectual function, similar in all respects to a presentation of dementia. A good history will reveal a rapid onset, and continued observation will demonstrate an intermittent alertness which makes the differentiation between the two fairly easy if one takes the time to look for it.

However, the differentiation in an elderly patient between depression and dementia is much more difficult. Often these depressed elderly individuals do not present in the typical manner of the younger patient who exhibits a sad mood, tears, inability to sleep, eat and so on. Frequently, an elderly depressed individual will present in what is known as an atypical fashion. He may simply sit in a corner staring at the wall and exhibit what we call psychomotor retardation—a general slowdown in mental and physical activity. Problems with attention, concentration, memory and other intellectual measurements are frequently compromised, making it appear remarkably like a dementia. It is obviously important to differentiate between a dementia and a depression because the treatments are so different and the success of treating an elderly individual with depression is quite good. But first one has to suspect depression and not automatically dismiss an older individual who is experiencing problems with intellectual function as being demented, because that frequently means no treatment at all.

Diagnosis is always important because of treatment issues. However, specific diagnosis is not essential in elderly intellectually-impaired patients when considering initiation of treatment. It is important to note here that all dementias can be treated. They can't all be cured, but they can all be treated. A better concept in treatment perhaps is total management. Management may be sub-typed into four categories: First, the disease-specific treatments—I already talked about someone having dementia, for example, with vitamin B12 deficiency; you treat that and that's a disease-specific treatment. The second category is pharmacotherapy or drug therapy, if you will, and/or psychotherapy, especially for those patients with dementias that are caused by the less-specific disease processes like Alzheimer's and multi-infarct dementias. These treatments should be directed at specific target signs and symptoms caused by these diseases because the specific underlying causes of these diseases are not yet known. It is important to note again that these treatments need to be carried out in a dynamic, ever-changing manner as the disease progresses over time and the patient continues to deteriorate.

Third, family education and involvement in treatment are extremely important and essential in these elderly patients with dementia, especially those with progressive diseases. As the patient continues to deteriorate and less can be done for him, the needs of the family and other care-givers are significantly increased.

The last treatment category in a similar vein to family involvement and education involves consultation and education with all the care-givers involved. This is essential in order to effect consistent, organized and, therefore, optimum treatment, and suggests a multi-disciplinary rather than a single discipline approach to carry out the best treatment of the patient with dementia.

To reinforce a major point about treatment, it should proceed even though a specific diagnosis may not be clear. This is true for two reasons. First, with elderly individuals exhibiting this unusual behavior, one frequently never has a clear-cut diagnosis. Mixed dementias and depressions are common in these patients, especially those who have spent much time, sometimes many years, in long-term care or other institutions with little sensory input or stimulation.

Second, the diagnosis of dementia, especially Alzheimer's, frequently produces in the care-giver a mind-set of nihilism; that is to say, there is the idea that nothing can be done for this problem and, therefore, there is no treatment given, except for perhaps over-sedating the patient so that he remains quiet and does not "disturb" anyone.

As dementia research in our GRECC and the VA generally and elsewhere moves forward looking for root causes, future treatments and prevention modes, present day patients with progressive diseases like Alzheimer's can be treated and managed at a variety of levels—medical, psychologic, socio-economic and so on. This comprehensive treatment must involve not only the patient but also family and other care-givers, as well as society in general, in terms of education, provision of support groups, and continued funding for basic and applied research.

That concludes my statement, Mr. Chairman, which was, of necessity, a brief overview of a complex subject. I would be pleased to answer any questions you or members of the committee may have.

[The statement of Dr. Gabe Maletta, with attachment, appears at p. 79.]

Dr. ROWLAND. Thank you very much.

What physical changes are found in the central nervous system in Alzheimer's disease?

Dr. MALETTA. Alzheimer's disease, as I am sure you know, is a disease of exclusion. That is to say, in a patient we will exclude all of the other causes of the intellectual decline over time, and we are left with an exclusionary diagnosis pretty much. Unless you do a brain biopsy while one is alive, one can only be sure Alzheimer's disease is present after death. At that point, neuropathologically, there are very specific changes which occur inside nerve cells, around nerve cells, which tell us that this patient did, in fact, have Alzheimer's disease.

Dr. ROWLAND. Do you think mental activity has any direct bearing on physical changes in the cerebral cortex?

Dr. MALETTA. That's an interesting question, the "use it or lose it" concept. I have no research data to suggest that that is scientifically true. I happen to believe that. The nervous system is an organ system. I think, without question, certainly physiologically, this occurs in other systems, though this would be anecdotal. As I say, I subscribe to that idea, although I can't prove it to you research-wise.

Dr. ROWLAND. Thank you, Dr. Maletta.

Mr. Penny?

Mr. PENNY. Dr. Maletta, in your work, do you deal with both patients whose problems are service connected and non-service connected? Is there a limitation on how you're able to follow through on those, for example, with Alzheimer's disease, which would not be service connected, because of the policy of serving service connected first? What have we done in your particular program area to make sure you're able to follow through and zero in on some of these health problems that are not service connected?

Dr. **Maletta**. Two points to make. One, personally, I don't know whether patients are service connected or not when I see them. The VA patients come to see us and we take care of them, whatever their status is.

We have in the GRECC a multidisciplinary approach. We have physicians, internists, neurologsts, psychiatrists, and also social workers, neuropsychologists and so on, who take their own histories from the patient, and then we get together with each patient at a team meeting after we see the patient and discuss these kinds of issues.

Frankly, I will treat anybody who comes to the hospital. The issue for me, as to whether someone is service connected or not, is really not an issue.

Mr. **Penny**. I think this question was asked of Dr. Gronvall earlier by the Chairman. Are we already establishing good communications with other health care facilities and other government agencies, regarding the kinds of conclusions that you have drawn in your study?

Dr. **Maletta**. We try very hard to be what I like to call entrepreneurial. We are involved directly with the university. We are involved directly with the community. In Minneapolis there are several philanthropic agencies, religious agencies, such as the Wilder Foundation, the Ebanezer Foundation in Minneapolis, that we directly involve ourselves with in terms of what we're doing. We have these people sitting on our local advisory committees, so that they come and sit with us on a regular basis to, in fact, help us in terms of future policy.

We also have a network at another level with the other GRECCs. There are three other GRECCs that are also involved with nervous system research, specifically in the area of dementias. We also involve ourselves with other VA's that do not have GRECCs—for example, Ken Davis at the Bronx VA. There is no GRECC there specifically, but we involve ourselves directly with other areas within the VA system that are interested in our own research. We also then, as was stated before, get involved with the academic and scientific community in general through the medical school and through our national organizations, that all of the staff members in our GRECC belong to.

Since it is multidisciplinary, we have internists and neurologists and psychiatrists, and they all go to different meetings. They all report in different journals and they all publish differently and they talk to different people. So in that sense, we like to think that what we're doing is demonstrating some very interesting concepts, not only in terms of clinical activity but basic and applied research, family education, other education of academics and so forth, and then trying, in fact, to spread this around within all of the spheres of our influence.

That's a long answer to your question.

Mr. **Penny**. Thank you. I appreciate it.

Mr. **Edgar** [presiding]. What's the status of the nurses strike in Minneapolis?

Dr. **Maletta**. I haven't been to Minneapolis for a couple of days. When I left they were still on strike.

Mr. **Edgar**. Still on strike.

Dr. **Maletta**. Not in the VA, however.

Mr. **Edgar**. Let me ask you a question about your intuition. You had indicated to Dr. Rowland that you thought as much activity as possible will help to keep a fairly alert mental process. It occurs to me that in many of our Older Americans Act centers, where senior citizens are coming for nutrition programs, where those programs are connected with some form of recreational outlet and outlet in terms of communication of socialization of people, that the quality of life for the elderly seems to be higher. It's an intuitive thing on my part. It is not something based on specific research.

I wonder if in two respects that doesn't happen with the kind of units that you operate in, both in terms of the patients' ability to interact with each other, but also in terms of the staff being able to interact with each other in terms of the multidisciplinary approach, kind of keeping them on the cutting edge of looking for specific diagnosis or being able to understand how to respond, what kind of things to say back to patients who exhibit a particular illness.

Do you have any reaction to that?

Dr. **Maletta**. I am a very strong proponent of multidisciplinary groups in nervous system disease because of what I said before, the biopsychosocial idea, and also integrated within a general medical center, not isolated somewhere as just simply a geriatric place. Again, these are my own opinions.

There are two things that came to mind as you were talking about the concept of stimulation. There are a lot of rat brain data, which I won't get into, which suggests that enriching the environment of early animals makes their brains bigger. There is no question about that. That was done at Berkeley many years ago and continues to be shown. But at the human level—you certainly can't extrapolate rat brains to human brains—but if you look at that problem in two ways, one, by, as you say, stimulating the patient in a day care center with lots of activity, clearly there are anecdotal changes where the patient and the family and the staff feel better.

The other side of that coin is, for years I have been going to a State mental hospital, one-half day a week. Instead of playing golf on Wednesday afternoons, as most doctors are supposed to do, I go off to the State mental hospital. What we see there is what everyone sees—institutionalization. Patients have been there for 35 or 40 years and they are now "institutionalized". I don't really know what that means, except these people have a very difficult time interacting with others. There is really nothing wrong with them in terms of what we can discern physically, but there is certainly a decrease in the ability for that nervous system, that individual, to respond and to react to other people. That is the other side of that. If you don't use it, if you sit and look out the window or watch television for 30 years, this is what happens.

Mr. **Edgar**. Or listen to congressional debates. [Laughter.]

Do you have any recommendations in terms of resources that you need, particularly as you contemplate moving into your new facility?

Dr. **Maletta**. Well, the new hospital is now being built, and I suppose we'll be finished with it by 3 or 4 years from now. We always could use more staff and more money, but that's my "wish list". Right now, I am very happy with the staff we have and with the involvement of the medical center. It has been very helpful.

Mr. **Edgar**. Thank you. I have no further questions.

Thank you very much.

Dr. **Boren**. Mr. Chairman, the next witness is Dr. Itamar Abrass, Codirector of the Sepulveda GRECC, who is going to speak on geriatric evaluation units.

Dr. Abrass.

STATEMENT OF ITAMAR B. ABRASS, M.D., CODIRECTOR, GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER, VA MEDICAL CENTER, SEPULVEDA, CA

Dr. **Abrass**. Thank you.

Mr. Chairman and members of the subcommittee, you have my formal statement, and what I would like to do for you today is highlight some of the things that I thought were particularly important in that statement.

Mr. **Edgar**. Without objection, your full statement will be made a part of the record.

Dr. **Abrass**. I am actually pleased to have the opportunity to talk to you about the issue of geriatric evaluation units, particularly the one that has been established at the Sepulveda VA Hospital.

In 1979 we began to develop our formal clinical program for geriatric care at the Sepulveda VA. At that point we asked the question, if we were going to have a special care unit for the elderly, what sort of specific issues should that address? At that point we decided that some of the things that were really not adequately addressed for the elderly population—and I don't just mean the VA alone but in general—were issues related to underdiagnosis, namely, missing disagnosis in the elderly; overtreatment despite the underdiagnosis; overuse of drugs and medication; relatively little use of rehabilitation in the sense of returning an elderly individual to the highest functional state of their ability; and ultimately placement, namely, the placement of elderly individuals who, in fact, could function in the community into an institutional setting.

It was while recognizing those problems that we developed our geriatric evaluation unit. We developed some specific goals related to that unit, namely, that to address these issues we would have these individuals undergo an intensive, interdisciplinary assessment that addressed their medical, functional, and psychosocial aspects, that we would then begin the treatment and short-term rehabilitation, that we would deal with the issue of appropriate placement, and then manage the long-term followup of these individuals within the setting.

We set up the unit as an interdisciplinary team of health care deliverers. The patients who come to our unit are admitted from the inpatient and from the outpatient units. From the inpatient units, these are individuals who have now stabilized their acute medical or surgical problems that require further care. They have a medical, functional, or psychosocial problem that is interfering with their discharge home.

In the outpatient department, these are individuals who are living in the community but who have difficulties coping in the community and therefore need care in our kind of unit.

These individuals are 65 years and older. We exclude only those individuals who have imminently terminal illnesses as far as that's concerned, or who are on life support systems, namely, those who require intensive care.

On our unit, the assessment and planning component takes approximately 1 week, and the treatment and rehabilitation component, if the patient needs it, lasts about 1 month. Then there is a followup period in our clinic for our patients who are discharged home and those who come back to the VA.

There have been two ongoing studies on our geriatric evaluation unit, both funded by the Health Services Research and Development Service of the VA. One is a descriptive study which has basically been looking at the outcome data on our patients over the past 4 years. A second one is one which is a randomized control study, comparing the kind of care that is delivered on our unit to that of the usual system and outcomes on patients. I will report to you about both of those studies.

In the first study, which covers 4 years of our operation, it turns out that about three-fourths of the patients who have been referred to our unit, admitted to our unit, were judged by the referring physician to require long-term care; namely, a skilled nursing facility or nursing home placement. Of all the patients who have come to our unit over these 4 years, two-thirds of them have, in fact, gone home or to a board and care facility or retirement home. Only one-fifth have gone to a nursing home.

If we look at the whole population, in fact, better than 50 percent of them are placed at a lower level of care than was originally judged to be necessary for them by the referring physician. Two-thirds of these patients have actually improved in their functional status as they leave our unit.

Another important thing that has occurred on our unit is that we make many new diagnoses on these patients. Many of them are treatable, and it ends up to be about three new diagnoses per patient. Despite the many new diagnoses we make, we, in fact, have reduced the number of drugs and drug dosage per patient by a third. So we feel that has been a benefit from our unit.

Now, as we look at trying to target the specific population to which this kind of service would be most appropriate, we have been able to identify some very specific things of those individuals who would benefit the most from our type of unit. It turns out that individuals over the age of 75, individuals who have what we consider specific geriatric disorders—that is, depression, dementia, postural instability, urinary incontinence—and those who, in fact, require some specific rehabilitative therapy, do better on our unit than individuals who are younger, namely, those who are between the age of 65 and 75, and those who have specific chronic, unstable medical problems such as congestive heart failure and pulmonary insufficiency.

Now, our randomized control study is still in progress, but the results have been very encouraging. The most dramatic result has been the issue of survival. It turns out that about half of the control patients, namely, those who received the usual care in our health care system, have died within 12 months of entering the study, whereas the survival rate, the death rate on the GEU population, has been less than a quarter over that same period of time.

The patients who have come through the geriatric evaluation unit have, in fact, reduced in half the use of nursing home and acute hospital days. Their functional status and their morale is also better than that of our control group.

Now, although the initial costs are higher by entry through the geriatric evaluation unit, this is more than made up by the later savings. Using VA cost figures, we have estimated that the GEU in fact saves approximately $5,000 per patient per year of survival.

Now, we feel that the data we have accumulated so far in fact indicates that a geriatric program like this geriatric evaluation unit at the Sepulveda VA Hospital has had and can have a positive impact on outcomes for the geriatric population, particularly if this is a targeted subgroup of the frail elderly.

Mr. Chairman, this concludes my comments, and I would be pleased to answer any questions that you or the subcommittee members might have.

[The statement of Dr. Itamar Abrass appears at p. 96.]

Mr. EDGAR. Would you mind commenting on the statement that appears at the bottom of the next to the last page of your statement and goes to the top of the last page, dealing with the financial savings of $5,000 per year?

Dr. ABRASS. Right. The major savings come really from the issue of admission to nursing home beds and readmission to the acute hospital, so that if we look at the population that has come through the geriatric evaluation unit as opposed to those who go through the regular medical, surgical, and rehabilitative services, the initial discharge to nursing homes is less off our unit; the later admission to nursing homes is also less, those who initially go home and then later are admitted to a long-term care facility, that is also less; and readmissions to an acute hospital after discharge from either site is also less. So the major savings really come ultimately from lower utilization of hospital bed days.

Mr. EDGAR. Are you tracking that in some formalized model?

Dr. ABRASS. Yes. The randomized control study is continuing. We monitor that at 3-month intervals. We monitor into the community those individuals, for example, who are placed in a VA nursing home contract bed. One of our research assistants will actually visit those individuals. We make home visits to those who are at home and cannot come back to our clinic. So every patient is tracked until the time that they die.

Mr. EDGAR. I was interested in your statement about people above the age of 75 do better than those below, given similar kinds of circumstances. Claude Pepper, a Member of Congress who is the advocate for seniors here, indicated recently that that's the fastest growing population I think throughout the whole age group—that is, those 75 and above are the fastest growing population. So that if, in fact, improvements can be made in that category, we may be helping, percentagewise, a fairly significant group of people.

Dr. **Abrass**. Yes, I think so. I think part of that reflects that you have to recognize the people who are 75 and over are survivors. They have something that has allowed them to survive that long. I think what happens in the population between 65 and 75 is that the individuals who require that kind of care, in that age, are probably more dysfunctional in the sense of the kind of problems that they may be presenting. So we may, in fact, be having a greater impact on that population.

Mr. **Edgar**. Let me ask you a question just in terms of your experience, not necessarily in terms of your research. Is there a point at which certain patients with certain diseases give up more quickly, in terms of their own futures and their own lives, and is there a way to counter the "giving up" process?

Dr. **Abrass**. Yes, I think that's true. I think we see on our unit individuals whose major problem, at least initially, is a medical one, a physical one. They then, although they don't develop what psychiatrists consider a frank depression, in the sense that one would need to make an intervention with drugs or intensive psychotherapy, in fact, they have a significant component of depression that relates to their dysfunction. If we deal specifically with the issues, as we do on our unit—and we have seen this quite a bit—a significant part of their rehabilitation really relates to dealing with just that issue; that is, we say "Yes, we're going to try to help you with your physical problems and at least help you; no, we don't think we can cure you, but yes, we can try to help you be more functional," and at the same time deal with those issues that we can overcome, just the kind of things you talked about.

We have had individuals come to our unit and have said, "Yes, I would like to die." These are people who do not have a specific diagnosis, say like cancer, where they may only have a short term. I am talking about individuals where you cannot pinpoint a specific cause for their immediate death, who said, "I would just like to die." We have dealt with those issues and they do very, very well. That's why I say individuals with depression have done particularly well in the setting we're talking about.

Mr. **Edgar**. Thank you.

Mr. Bilirakis.

Mr. **Bilirakis**. Mr. Chairman, not having been here throughout the entire hearing, I don't know whether this question was asked, and if it was, and answered, we can get it out of the record. But I just wondered if the doctor could tell us, might we reasonably, or might we, in our wildest dreams, be able to relate the stresses of military service to Alzheimer's?

Dr. **Abrass**. Well, again, that hasn't been addressed, I don't think, and I will give you my answer to that—and maybe Dr. Maletta could have also answered that for you.

Personally, I don't think so. My understanding of Alzheimer's disease is that, at least as we understand it—first of all, it's multifactorial. It probably is a syndrome rather than one disease. But if you look at it across populations around the world, there seems not to be one area that specifically has a much higher incidence or prevalence of any Alzheimer's type dementia. So I think overall one would probably have to say that there is not good evidence, at least from that issue, that there is that kind of ideology.

Now, there has been some correlation with the issue of previous trauma, specific head trauma, and the issue of developing later dementia and whether that ends up really looking like Alzheimer's disease. So I think individuals who may have had specific head trauma may be at risk, but I don't think there is evidence that the specific issue of stress is related to that.

Mr. **Bilirakis**. Thank you.

I have nothing further, Mr. Chairman.

Mr. **Edgar**. Mr. Penny.

Mr. **Penny**. No questions.

Mr. **Edgar**. Mr. Shelby.

Mr. **Shelby**. I have no questions.

Mr. **Edgar**. You mentioned some analysis of looking around the world at Alzheimer's disease, which raises just one question in my mind.

Are there any specific diseases related to being an American related to aging? Do we have any unique concerns here in the United States, or are we relatively better off in terms of nutrition and things like that?

Dr. **Abrass**. I think we are better off in some aspects. I think clearly one of the things we have talked about, the major issues that relate to the diseases of aging and the causes of death, particularly cardiovascular disease and cancer, stroke, and stroke in its relation to hypertension, stroke having been the one disorder that, in fact, seems to be decreasing in its prevalence over time, may be again related to our changes.

Now, no one has specifically related to it, but our changes in lifestyle, better diagnosis of hypertension and its treatment. So we have made an impact on that particular disorder. But I think, other than that, we are at risk for the diseases of aging, and Alzheimer's is one of them where we're really not different, certainly hypertension and cardiovascular disease, cancer, diabetes mellitus.

Mr. **Edgar**. Thank you. I have no further question.

Mr. **Penny**. Mr. Chairman.

Mr. **Edgar**. Mr. Penny.

Mr. **Penny**. This may not be a question for which anyone here has an answer. But in response to a news item I heard recently, and given the fact that reference was made to a comparison of our health care for seniors as opposed to health care systems around the globe, I was wondering if you're familiar with why, in the Soviet Union, the longevity apparently has declined, whereas most other developed and developing nations are experiencing longer life spans.

Dr. **Abrass**. One, I think part of that may be a little bit a mishandling of the data. I think some of the initial excitement from the Russian population came from the Caucus area, where there were specifically some individuals who, in fact, were said to be over 100 years old and functioning very well. It turns out, I think, as one has looked at that very carefully—because records were not very carefully kept, and because, in fact, birth certificates may have been changed and ages were changed, so that these individuals were not drafted into the Czar's army and all that—is that they are not quite as old as we thought.

Their lifestyle in that area has really changed. They are older. There is no question that there are individuals in their eighties and nineties in that population. It is just that they're not living to 130 and 140.

I think one of the things that has clearly changed there is that the individuals we are now looking at, who are in their nineties, individuals who have worked very, very hard all their lives and continue to do that, in fact, probably their diet has changed a lot. It is probably from an agricultural point of view, one of the richer areas of Russia. Right now, in fact, I believe individuals in their twenties, thirties and forties, are living a totally different life and are eating very differently, and I wouldn't be surprised if, in fact, they may end up living not quite as long as that population. We just don't know that.

We only know in animal models that have been looked at that, in fact, what turns out to be some dietary restriction leads to greater longevity. Whether that means eating as much as you like decreases your life span, or whether restricting your food increases your life span, is an issue that doesn't make, I guess, that much difference, other than saying that, in fact, either food restriction or eating less than eating everything you can possibly get your hands on is good for you. But I think that may be part of what's happening.

I wonder, Mr. Chairman, if I maybe could address one issue that you asked before, which was the question of having geriatric evaluation units at every VA. I think that is an important issue.

I want you to know that ours was really the first geriatric evaluation unit of its kind in the VA in this country. We modeled ours much on the British system, where they have had specific programs for the geriatric population for a long time. There had been other assessment programs within the VA—namely, short term—but ours was really the first intensive comprehensive one where there was assessment, treatment, rehabilitation, and long-term followup. So ours is really the first one that has demonstrated this kind of benefit.

I think we need to be sure that, before we really institutionalize this sort of concept, we know that this is the kind of approach we want to take. That was really the reason we did this in a study mode, rather than just establishing it. This needs to be done in other VA medical centers, in different settings. I don't think necessarily the model we have used needs to be done in every place. I think there should be, for a targeted population, some specific geriatric programs, but I think we need to decide what those best programs are and also need to look at the same kind of issue in the community.

I think the other thing we still need to look at very carefully are some of the issues that relate to the instruments we use for assessment. The issue of reliability, of its validity, of the interrater reliability; namely, my giving it to a patient at Sepulveda relative to somebody else giving it in Minneapolis relative to somebody else using that same instrument in Boston. There still has to be a lot of work. We have different instruments. Different people use different criteria, and that is one of the other important areas that I think we still need a lot of research in.

Mr. EDGAR. Will we need a time certain to determine at a particular point in history or in the future we should make a decision?

Dr. ABRASS. Yes.

Mr. EDGAR. Because it seems to me that we could get to the year 2000, having set up lots of different kinds of units, and not really gotten to a point of actually making a decision.

Dr. ABRASS. I can answer that for you.

We, last year, in conjunction with the Office of Geriatrics and Extended Care, set up a national program for VA medical centers that were interested in developing this kind of unit. We are planning another one this particular September for other VA medical centers. In conjunction with the Health Services Research field program at the Hines VA, we are developing a specific assessment of outcomes in these units that are being established. So we will have the data in a broader way fairly soon.

Mr. EDGAR. Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, again, I think we maybe kind of danced around this, unless, again, it was covered during the time that I was gone. But I just wondered if maybe we can have a brief answer to this from Dr. Gronvall.

To what extent is research being done with respect to the aging process of veterans with severe service-connected disabilities? In other words, those service-connected disabilities not really being related directly to the aging process, but to what extent is research being done with respect to the aging process for those particular veterans who have those severe service-connected disabilities?

Dr. GRONVALL. Mr. Bilirakis, I don't really think I can give a brief answer to that. What I would do, if I tried to answer it, I think I would have to embark on some discussion about the kind of research going on with each of a whole series of specific problems and conditions. I really don't think I can find any way to summarize that.

Mr. BILIRAKIS. I wonder if we could possibly get that submitted for the record, if Dr. Gronvall's office could submit that to the committee.

Dr. GRONVALL. We would surely be pleased to do some organized thinking about that and present it in a way that would respond to your question.

[Subsequently, the Veterans Administration furnished the following information:]

Research and Development has identified research on problems of aging as a special priority area. This research currently deals with four broad topics: (a) specific disease processes associated with aging, i.e., alcoholism, arthritis, cancer, diabetes, heart disease, hypertension, chronic obstructive pulmonary disease, genitourinary disease, spinal cord injury, schizophrenia, (b) underlying "normal" changes associated with aging, such as those studied by the Boston Normative Aging Study, (c) cost-effectiveness of alternative arrangements for health services delivery, and (d) alternative approaches to rehabilitation. Research in all these areas is pertinent to those veterans with severe service-connected disabilities referred to in your question. This research is conducted by investigators at VA medical facilities, including those with special clinical, educational and research centers, i.e., GRECC's, HSR&D Field Programs, Rehabilitation Research and Development Centers.

You may be especially interested in knowing of some of the specific studies supported by the VA that address the interaction of disability (observed or hypothesized) and the developmental or aging process. Included in this group are:

Cardiovascular Risk Factors in Amputees.—What are the rates of mortality and coronary artery disease within the amputee group? What are the risk factors for these events?

Vietnam Veterans Head Injury Study.—What are the neurological, anatomical, speech pathological neuropsychological, motor, auditory, and electrophysiological sequelae of penetrating head injuries?

Study of Former Prisoners of War.—What are the long-term health consequences of having been a prisoner of war?

Agent Orange Studies/Post Traumatic Stress Disorder Studies.—What are the long-term health consequences of exposure to Agent Orange and of the experience of Vietnam service?

In addition to the research referred to above, Rehabilitation Research and Development Service gives special attention to studying the exacerbating effects of aging on existing service-connected disabilities such as amputation, spinal cord injury, blindness, deafness, and communication disorders. Rehabilitation R&D directs its efforts to improved procedures and devices for preventing and treating age-complicated disabilities. The Health Services Research and Development Service is presently exploring the possibility of conducting a retrospective mortality study of veterans who sustained spinal cord injuries in service.

Mr. **Bilirakis**. Thank you, sir.

Mr. **Edgar**. Are there additional questions? Before Mr. Penny leaves, I might indicate that we are not going to ask Dr. Boren to develop a research project on vodka versus water in the Soviet-American aging process. [Laughter.]

I appreciate your testimony and we will go to our next witness.

Dr. **Boren**. The next witness is Gwenyth Vaughn, Ph.D., from the Birmingham VA Medical Center. She is going to speak on and demonstrate remote machine assisted treatment and evaluation, the acronym for which is REMATE. Dr. Vaughn will be assisted by Robert Lightfoot and Ramona Faucett.

Dr. Vaughn.

Mr. **Edgar**. While Dr. Vaughn is coming forward, let me yield to Mr. Shelby for a word of welcome.

Mr. **Shelby**. Thank you, Mr. Chairman. I appreciate this.

I came over, like a lot of people here, to see Dr. Vaughn's demonstration. It seems like it is right at the cutting edge of high technology. It deals with communication in a real sense and also dollar savings for the American taxpayers which will really impact on the VA programs.

Dr. Vaughn, although I'm from Tuscaloosa, I represent some of the Birmingham area and I welcome you, as the chairman would, to Washington, and look forward to your demonstration.

STATEMENT OF GWENYTH R. VAUGHN, PH.D., CHIEF OF AUDIOLOGY-SPEECH PATHOLOGY, VA MEDICAL CENTER, BIRMINGHAM, AL, ACCOMPANIED BY ROBERT LIGHTFOOT AND RAMONA FAUCETT

Dr. **Vaughn**. Thank you, Mr. Shelby.

Mr. Chairman and members of the committee, I am Gwenyth Vaughn and I have been chief for 17 years of the audiology-speech pathology service at the Birmingham VA Medical Center. For 18 years I have been a professor of bio-communication at the Schools of Medicine and Dentistry, University of Alabama in Birmingham.

Dr. Boren already introduced my two staff members, and I would like to say they are outstanding clinicians. Of course, our patients are much more interesting than any of the three of us, so we're going to make very few comments and let them demonstrate our health care delivery system.

Presently, I am the principal investigator of a 3-year research project for our rehabilitation research and development service. The project is called "Efficacy of Remote Delivery of Aphasia Treatment by TEL-Communicology." TEL-Communicology is a term I devised to describe the delivery of services by telephone to veterans with communicative disorders.

Two things that might be of interest to you is, although Birmingham is the study center, we have three other centers working with us in Little Rock, Miami, and New Orleans.

TEL-Communicology has two aspects—clinician assisted, in which you will see Mrs. Faucett calling and working with the patient over the telephone. I would like to emphasize that we are not trying to replace all face-to-face treatment with telephonic supplementary care but, considering the quality of care with intense and frequent and long-term care, the fact that it is remote.

I appreciated your statement about your looking for remote delivery systems. We think we have one that not only will serve people with communicative disorders, but I believe my boss and CO has about 11 other disciplines that are seeing how our research rehab project is going to turn out.

We are looking to see if it is equally as good face to face, about as good, or better, so that we can really save millions of dollars in travel. Besides, many veterans have other health problems who really can't travel round trip the 170 miles to Birmingham. I think at 9,000 sessions by telephone we will be doing this year, we could save about $99,000 in travel.

Second, which Dr. Boren mentioned, we have a whole configuration of computers that we call REMATE, remote machine assisted treatment and evaluation. Somehow REMATE is taking on a personality of its own and sometimes the patients will call up Mrs. Faucett and say, "You know, he said turn the page. I kept saying, 'Well, I don't have that page.' He kept saying turn the page." So that we are finding many patients are enjoying working with the computer greatly. If one of the work study students left a page out, it becomes a major thing and we get a telephone call immediately.

Our first demonstration, Mrs. Faucett is going to assume the role of a patient receiving a treatment program delivered by the REMATE computer from the Birmingham VA Medical Center. The REMATE computer will provide the voice stimuli and Mrs. Faucett will use a touch-tone telephone to signal her responses.

In all of our projects we try to use items that are already on the market, easily accessible, and cost effective.

You will observe that she has a notebook which we placed over the telephone, and we don't expose the touch-tone keys that will have the specific responses. I don't know whether Ramona will make any errors, because if she does, REMATE will tell her, "Try that again." With REMATE, we can telephone any veteran in the Nation.

[The statement of Dr. Gwenyth Vaughn appears at p. 101.]

Dr. **Vaughn**. Ramona.

Ms. **Faucett**. I might mention that the program that I have is a reading program. At the top of the page it says light and blank, and then there are four choices. I will make a selection. The materials, of course, are suited to the particular needs of the patient. So that you will know what I'm doing, I will make a selection and then he will respond as to whether it is correct or incorrect.

[Demonstration follows:]

REMATE: "Hello. This is REMATE calling. Signal if you are ready. [Signal] Fine. Let's get started. This is REMATE program 5. Open your notebook and signal when you are ready. [Signal] Page 1. That's right. Page 2.——"

Ms. **Faucett**. This says "Army and . . ."

REMATE: "That's right. Page 3."

Ms. **Faucett**. It says "War and . . ."—and I'm going to choose "poem".

REMATE: "No, that's not right. Try again. [Signal] That's right."

Ms. **Faucett**. That time it was peace, "war and peace."

Dr. **Vaughn**. REMATE not only typewrites, but it touch-tones and talks, and also receives those same communicative modes. We thought that in the next patient—maybe Mr. Shelby would like to write back and forth with a patient that's in Cullman, AL. We won't insist on that.

Someone suggested that if we showed you a very quick videotape, you might understand better what we're doing. I don't know if all you gentlemen can see the video. It is only a minute-and-a-half long. But while we're getting that up, I would like to mention that when we did a 1-day annual census in the VA, 21,300 veterans were identified as having speech disorders. Seventy percent of the veterans in VA outpatient clinics had speech disorders, and 90 percent had hearing problems in the nursing homes.

As the veteran population ages, the percentage of hearing and speech problems will increase. One in ten of the U.S. population has a communicative disorder.

So if you would like to go ahead with the videotape. You will see simultaneous writing afterward, if you want to come down here and watch a live patient.

[Video film presentation.]

Dr. **Vaughn**. In aphasia, they often have to use their left hand because their right hand is involved and they have to learn to write over again.

A person with aphasia may have trouble speaking or understanding what is said to him, or to read or to write. We are very proud that we have been able to put some veterans back to work. They go to work 30 minutes late in the morning; we go to work early. By telephone, Mrs. Faucett has been able to teach them to write again.

Ms. Faucett, would you introduce Mr. Davis, who lives in Cullman, AL, and from the Birmingham VA Medical Center?

Ms. **Faucett**. Yes. Dr. Gianinni asked me to mention also to be sure that you had understood on the REMATE demonstration that that was coming from Birmingham.

Now, this patient is in his home. He is a 62-year-old-man who is a retired locksmith. He had a stroke in September of 1980. He's in Cullman. He can stay in Cullman, which is about 60 miles from

Birmingham, and receive his treatment by telephone because travel is somewhat difficult for him.

To give you a little bit of an idea of the problem he has, initially when we tested him he was at the 39th percentile when compared with other stroke patients. Now he is at the 69th percentile, so he has made significant gains in his ability.

Let me plug him in the Telenote, and those of you who would like to watch, feel free.

Mr. Davis?

Mr. **Davis**. Yes.

Ms. **Faucett**. How are you this morning?

Mr. **Davis**. Fine. How are you?

Ms. **Faucett**. I'm fine. How's Alabama?

Mr. **Davis**. OK. It's hot.

Ms. **Faucett**. It's hot in Washington, too.

Are you ready to do a little work for us?

Mr. **Davis**. Yes, ma'am.

Ms. **Faucett**. OK. I'm going to give you some sentences and I will leave off the last word. I would like for you to finish it for me, OK?

Mr. **Davis**. OK.

Dr. **Vaughn**. Now, this is his handwriting coming instantaneously over the telephone line. In fact, we have even been able to detect a second stroke because of deterioration in the handwriting, to bring the patient in for treatment.

Ms. **Faucett**. OK, that's good.

Could you read that sentence for me, please?

Mr. **Davis**. I sit in a chair.

Ms. **Faucett**. Very nice. Let's try one more.

Mr. **Davis**. OK.

Ms. **Faucett**. This pen duplicates the movements of his pen on the other end, so he is kind of following along, figuring out what comes next.

Very good, Mr. Davis. Read that one for me.

Mr. **Davis**. I eat with a fork.

Ms. **Faucett**. Terrific.

Let me see if any of our guests have any questions or if they would like to talk with you.

Mr. **Shelby**. I want to ask him, how long has he been able to understand and then communicate back, like you are giving him parts of a sentence and then letting him finish it. Has this been a progressive thing?

Ms. **Faucett**. We can ask him, but let me explain something first.

He can do more difficult things. When I am showing off a patient, I always give them something easier. So really, he is in treatment now. We are working on giving him two words and having him put those two words in a sentence. So he has probably been able to do this task for quite some time. But we'll ask him.

Mr. Davis, one of the gentlemen has asked, how long have you been able to do this task? How long have you been able to work at completing a sentence? Can you remember?

Mr. **Davis**. No, I sure can't.

Mr. SHELBY. You said he had gone from the 39th percentile to the 69th percentile——

Mr. DAVIS. Two years.

Mr. EDGAR. He just said 2 years.

Ms. FAUCETT. OK, good.

Mr. SHELBY. A 2-year period? Over what period of time?

Ms. FAUCETT. Well, let's see. September of 1980, so he's been in treatment over 3 years. He's had quite a lot of treatment.

Mr. BILIRAKIS. He was literate. He knew this before and then he got sick.

Ms. FAUCETT. Sure, exactly. He had a stroke in September of 1980 and lost his ability to write as a result of that. So definitely, he had these abilities before.

Mr. EDGAR. Let me talk to him real quickly.

Ms. FAUCETT. Sure. Just put your finger on that button.

Mr. EDGAR. Mr. Davis, this is Congressman Bob Edgar. I am chairman of the committee. With me is Congressman Shelby from Alabama and Congressman Bilirakis from Florida. We want to thank you for demonstrating this particular treatment to us at our hearing.

Mr. DAVIS. OK. [Laughter.]

Mr. EDGAR. You let us know if they're not treating you well.

Mr. DAVIS. OK.

Mr. EDGAR. Thank you very much.

Mr. DAVIS. You're welcome.

Dr. VAUGHN. I want to say that when we travel around the United States, and our patients are our best examples, they bring in their family members, and in a small town you may have the whole family and all their friends sitting there, because instead of being a rejected person who can't talk and write, he becomes the outstanding citizen. They are very proud to help us teach other speech pathologists how to use this equipment.

Another thing that I think is important, as you know, a lot of veterans may not have friends or family members, so the speech pathologist or audiologist may be their one contact with the outside world. We often can put them on hold on the telephone, call social services, call the M.D., call the pharmacy, whatever it is that patient needs, so we can provide them with all-around care.

The third demonstration is going to be a TEL–C clinician-assisted program for an alaryngeal patient, because TEL–C helps us provide services for patients who are unserved, underserved, and live in remote areas.

An alaryngeal patient is a person who has lost his larynx or voice box, because of cancer generally. We have a couple of alaryngeal devices here if you want to see them. Mr. Ferrity from the Philadelphia VA Medical Center is going to demonstrate both his alaryngeal speech and the use of an alaryngeal device.

We will show the video first, and then we thought Mr. Edgar might want to speak to Mr. Ferrity.

[Video film presentation.]

Ms. FAUCETT. Let me tell you a little bit about Mr. Ferrity. He is a 48-year-old man who is a retired electronics technician from the Navy. In December of 1982 he had his voice box surgically removed for cancer. He had a number of complications following that and actually hasn't gotten very intensive speech treatment until January of 1984. He received speech treatment at the Philadelphia VA.

When I asked him if he would be interested in working with us for this project, he said it was fine, as long as he didn't have to learn to talk with a Southern drawl. So I told him, if he didn't make me talk like a Yankee, I wouldn't make him talk like me.

He is doing a good job with his speech. He still is at the beginning stages. He does a nice job with his artificial larynx and is beginning to get some esophageal speech, so I will demonstrate both for you.

Mr. Ferrity.

Mr. **Ferrity**. Yes, ma'am.

Ms. **Faucett**. How are you this morning?

Mr. **Ferrity**. I'm fine, thank you.

Ms. **Faucett**. Good. We appreciate your helping us with this demonstration this morning.

What I would like to do in the beginning is just to work with your Servox just a few minutes and make sure it's working well, OK?

Mr. **Ferrity**. Yes, ma'am.

Ms. **Faucett**. Let's try some sentences. Put it down now and come here.

Mr. **Ferrity**. Put it down now and come here.

Ms. **Faucett**. Sounding nice and clear.

Pick it up soon and bring it home.

Mr. **Ferrity**. Pick it up soon and bring it home.

Ms. **Faucett**. Very, very good.

Let's try just a few things with esophageal speech. Let's warm up with pay.

Mr. **Ferrity**. Pay.

Ms. **Faucett**. Good, nice and clear. P.

Mr. **Ferrity**. P.

Ms. **Faucett**. Good. Pie.

Mr. **Ferrity**. Pie.

Ms. **Faucett**. Poe.

Mr. **Ferrity**. Poe.

Ms. **Faucett**. Sounding good. Let's try some things a little longer. Party.

Mr. **Ferrity**. Party.

Ms. **Faucett**. Very nice. Picture.

Mr. **Ferrity**. Picture.

Ms. **Faucett**. Painting.

Mr. **Ferrity**. Painting.

Ms. **Faucett**. Good. I'm going to make you stretch. Try this one. Put it down.

Mr. **Ferrity**. Put it down.

Ms. **Faucett**. Super. Pick it up.

Mr. **Ferrity**. Pick it up.

Ms. **Faucett**. OK. I'm really going to make you stretch. Put it down now.

Mr. **Ferrity**. Put it down now.

Ms. **Faucett**. Hey, very good. Pick it up soon.

Mr. **Ferrity**. Pick it up . . .

Ms. **Faucett**. Let's try that one again.

Mr. **Ferrity**. Pick it up soon.

Ms. **Faucett**. OK, very good.

Congressman Edgar would like to speak with you.

Mr. **Edgar**. This is Congressman Bob Edgar. I am chairing a hearing on health care in Washington. I want to thank you for your help.

How are the devices working?

Mr. **Ferrity**. Very well.

Mr. **Edgar**. You have been in therapy since January?

Mr. **Ferrity**. Yes, on esophageal speech.

Mr. **Edgar**. I hope our demonstrator doesn't force you to talk southern.

Mr. **Ferrity**. Well, I can do a little bit of that, too.

[Laughter and applause.]

Mr. **Edgar**. You all done real well. [Laughter.]

We appreciate your taking the time to demonstrate this. This is a third of a series of hearings on the VA's research efforts and we are trying to decide and discover how to expand the research capabilities to help other patients like yourself. You have been very helpful to us this morning.

Thank you.

Mr. **Ferrity**. You're welcome, sir.

Ms. **Faucett**. Mr. Ferrity, thank you so much. I taught you a lot of Southern in just a few short lessons, didn't I?

Mr. **Ferrity**. A little bit.

Ms. **Faucett**. OK. You did a nice job and we appreciate your help. I will be talking with you after we get back home.

Mr. **Ferrity**. All right.

Ms. **Faucett**. Bye-bye.

Dr. **Vaughn**. I would like to comment that, as you all well know, communication is one of the most important and complex of human activities. In fact, being able to talk with your physician and your priest or your businessman or your banker can make a big difference in whether you're successful personally, socially, educationally, vocationally, clinically, recreationally, and so forth.

I would also like to comment that the VA has the best hearing aid program in the United States. Mr. Lightfoot, who is a rehabilitative audiologist, calls over a thousand of our veterans each year and checks to see how their hearing aids are doing. We are hoping that, thanks to our rehab project, that we're going to demonstrate TEL-C as being so effective that we will be able to put in a follow-up of all the hearing aids in the United States by calling them at least once a year to see how they are operating and how they're doing.

That completes our demonstrations. I would be pleased to answer any questions you would care to ask me.

Mr. **Edgar**. I appreciate your testimony. I also appreciate your staff coming and helping to demonstrate.

Let me just share a personal comment. I am concerned about the decision that has been made by the courts and to some extent by Congress in terms of the cost and pricing and the breakup of AT&T. I think that what you have demonstrated this morning, specifically as it relates to how health care can fit into normal, everyday activities and therapy can take place in the home, indicates that we ought to keep telephone prices and accessibility as low in terms of price and as high in terms of accessibility as possible.

I have a fear that some of the elderly, some of the indigent patients that we serve, as health care costs increase, are going to be cut off. I know that some patients, for example, have hookups with their local hospitals, and certain communities have a telephone networking system where they try to keep in touch with aging patients.

I think the expansion of the things you have seem to me to be unlimited. For example, we saw on the video, just the one-on-one, there is no reason why you couldn't have a group of like patients all taking a similar course over both a telephone and a tele-video setup, and if we can keep the costs and the accessibility of that within range, I feel more help can be given.[1] It's really a personal concern on my part, that we have to watch carefully the movement toward more competition, and yet the feeling that many people have that that's going to skyrocket costs.

Let me ask one question of your therapists that have been helping. Have you done any work with computers hooked up to homes of patients? For example, it seems to me your telephone demonstration, where you're telephoning with your book, trying to get them to give the right responses, that through home computers hooked up to another home computer you could have some of the same kind of interaction.

Ms. **FAUCETT**. Not actually. Our last research project, of course, dealt with the development of REMATE, and Dr. Vaughn could speak more to that. REMATE is the central computer that anyone can call into. We have such a variety of programs. But as far as working with home computers, we haven't specifically done that.

I don't know if Dr. Vaughn would want to add anything.

Dr. **VAUGHN**. So far we have kept to the touch-tone telephone because it is so inexpensive. We can make them compatible, and we have been considering that. However, I guess we're trying to be a little bit different because we think that a home computer might be a device unto itself, while REMATE can evaluate what the patient's answers are and immediately give the printout to the clinician. She can call up and check what's going on.

But I think you have a very important point, and perhaps next year we can—I don't know if Apple Co. will let us have their software or not, but we'll be looking into that.

Mr. **EDGAR**. I have the capability at home to plug into my office computer and to edit letters or pick up the UPI wire service. I don't use it very often to send messages or receive messages, but the capability is there. It just seemed to me with patients who do have the ability to respond to sentences by using the touch points on a telephone might advance a step forward and use the other. But that is not to understate the value of just using the telephone in a positive way.

Are the costs in Alabama for telephone service going up substantially?

Dr. **VAUGHN**. Well, we're using FTS at the moment, and I talked to AT&T yesterday and it had been basing the costs on 28 cents a minute. This man said 30 cents a minute now. But compared to 11 cents a mile for a 170-mile round trip, we're still winning the battle on cost savings. But I think your point is well taken.

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[1] See p. 105.

Mr. **EDGAR**. Maybe AT&T would be willing to reduce costs for—

Dr. **VAUGHN**. I have been trying to get a foot in the door. They keep sending people down to visit us, and then they promise great things, and then I never hear from them again. But yesterday I had a couple of new contacts.

I think we're the best thing that ever happened to the telephone system and I think they ought to show us a little consideration. Perhaps now that you all know about us, we can team up together and get some attention.

Mr. **EDGAR**. Thank you. I don't have any further questions. Thank you very much for a meaningful demonstration.

Dr. Boren, do you have any additional comments you want to make in summary?

Dr. **BOREN**. I would like to thank all the witnesses for a superb morning's presentation. I think it demonstrates the comprehensiveness and the breadth of the VA research program. We have seen everything from basic medical research through the Geriatric Evaluation Units by Health Services to rehabilitation research. I am very appreciative of the opportunity of showing you these programs, Mr. Chairman.

Dr. **GRONVALL**. The only thing I would say in closing, Mr. Chairman, is that for me personally this has been a very moving experience to see brought together in one place all of these splendid examples of what can be accomplished. And since I am in a position where I can take no credit for it, I share in an unabashed expression of joy at seeing what has been going on through the system and what the system holds out for the future. It has been a delight to make these presentations.

Mr. **EDGAR**. Well, I would like to thank you and also Dr. Boren for participating in all three hearings. I think the hearings demonstrate that this committee is interested in the level of expenditure, the extent of the research, and the specifics of that research. And while this is the last of the hearings this year, if and when reelection occurs next year, and if and when I return as chair of this subcommittee, I anticipate that we will have additional hearings on specific areas of research, and that we ought to continue the dialog back and forth as to areas that might be helpful to explore, that would not only help the veterans but also help the health care community across the country.

Dr. **GRONVALL**. We very much appreciate your support.

Mr. **EDGAR**. Thank you very much.

Mr. **EDGAR**. Let me now call the panel of veterans' organizations, Colonel Houston from the Veterans of World War I, Dr. Stocking from the Blinded Veterans Association, Mr. Gorman from the Disabled American Veterans, Mr. Powell from the Paralyzed Veterans of America, and Mr. Donald Schwab of the Veterans of Foreign Wars.

Gentlemen, I am going to ask each of you to summarize your statements. The full text of your statement will be made a part of the record. We ask that each of you take no more than 5 minutes in your testimony. We appreciate your patience again this morning in listening to the witnesses and to being part of this hearing process, of looking at the questions relating to aging veterans.

Let's begin by having Colonel Houston start off.

STATEMENTS OF HERBERT M. HOUSTON, LEGISLATIVE DIRECTOR, VETERANS OF WORLD WAR I; GEORGE E. STOCKING, NATIONAL LEGISLATIVE COMMITTEE CHAIRMAN, BLINDED VETERANS ASSOCIATION; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF COL. HERBERT M. HOUSTON

Colonel HOUSTON. Mr. Chairman, members of this distinguished committee, I wish to thank you for the invitation of appearing before you to present to you the thinking and views of the membership of the Veterans of World War I pertaining to hospitals and health care. I invite you to read carefully our full statement.

My name is Herbert Houston. It is my pleasure to serve as legislative director and chairman of the national legislative committee of the Veterans of World War I.

Ad-libbing just a moment, Mr. Chairman, I could not help but marvel at the program preceding this one. Going back to my college days, I remember reading in medical history of where the remedy for asthma was to back a child up to a tree and bore a hole in the tree and put hair in and then cut the hair off, and when he outgrew that, he would be cured of asthma. It is such a contrast to the medical science we have seen demonstrated here.

Another one as bewildering as that, if you remember the famous debate at the University of Paris, of how many angels could dance on the point of a needle, that, too, is as bewildering as the technical advancement of all these hormones that these doctors talk about. But it is elevating and we only have God in Heaven and a Government like ours to develop a program like this.

I am a veteran of World War I and a veteran of World War II. I remember the battle casualties of World War I and what we called shellshock. It was my privilege to bring back a boatload of veterans from World War II from the Solomon Islands who had the same malady. It is interesting to listen to these doctors talk today about the treatment that these veterans are getting in the hospital, and I sit in bewilderment at the change in medical treatment.

The Veterans of World War I are concerned with the problems of the aged as a national challenge. However, they are more vitally concerned with the plight of the veterans of World War I for the reasons herein mentioned, because they have been denied their potential. We represent the 280,000 members of the octogenarian veterans, and I am the only representative of that group before you today, a member of the last men and women's club of the veterans organizations.

Mr. Chairman, there is a difference between the outlook on life and the psychological life of the veteran of World War I and subsequent wars. The veterans of World War I have, from the date of their discharge from the military service, been disadvantaged in two categories. They were and are until this day America's only war veterans who were not provided adjustment to civilian life when they came out of the service—that is, with the exception of the service connected. Some 260,000 were provided educational and vocational training, but the 4.5 million of them were discharged and inevitably forgotten, as if they were expendable. This was as great a psychological shock as battle fatigue.

The second category was the Depression of the thirties. The average citizen of the age of the veterans of World War I has been the recipient of employment during the war years, and he could have planned for his future. The veteran of World War I was deprived of employment because of the Depression, and by the Government because it refused to have adjustment benefits. This has been provided for veterans of subsequent wars.

Unknown to many, there has been a vendetta existing between the veterans of World War I and our Government since 1920, when the veterans were seeking legislation as a recompense for war time service, and denied to them by the opportunity to education or craft which would have enabled them to provide a livelihood for themselves. Reams of paper have been used by the Government in making replies to millions of letters asking why. Did they do something wrong? Did they win the war too soon?

There is a psychological scar on the veterans of World War I that no hospitalization can erase. My attention was brought to this travesty during the early sixties by an article in the Saturday Evening Post by a Government official seeking to justify why the veterans of World War I did not need special legislation. That article did not ring true to me and, in plain language, it didn't smell right. So I began to look into the legislation of the veterans benefits.

This group of veterans have this committee to thank, starting with the enactment of Public Law 96-151, and each veteran of World War I thanks this committee to this day for the enactment of this legislation. It was the only real benefit provided by the Government to the veterans of World War I, because it provides outpatient treatment and medical care which is far better to the majority of the veterans of World War I than nursing homes or even a hospital, unless it is absolutely essential. Home therapy is better than nursing home care, if possible.

Old cavalry horses were turned out to pasture. We feel that the old soldiers of World War I need the same consideration by the Government, by furnishing these health needs.

Thank you.

[The statement of Colonel Houston appears at p. 106.]

Mr. Edgar. Thank you very much for your testimony.

Dr. Stocking.

STATEMENT OF GEORGE E. STOCKING

Dr. Stocking. Thank you. I appreciate the opportunity to appear before your subcommittee, Representative Edgar, and the other members of the committee. The Blinded Veterans Association, as you know, was established at the end of World War II to promote rehabilitation and independence of blinded veterans.

I was impressed by Dr. Maletta's comments on the holistic approach to treatment of dementia in aging. That is the type of approach that the Blinded Veterans Association is interested in providing for the aged blinded veteran. When our organization was founded, the average age was about 23 years. These veterans are now over 65. About 75 percent of these service-connected blinded veterans had multiple disabilities. In our youth, with the proper rehabilitation training and with the resilience of that youth, we were able to reduce the limitations placed on us by those multiple disabilities. As we age, that resilience is leaving us. The possibilities for our reducing these limitations are leaving us.

The VA, at present, from what we understand, in their aging plan, program or report, as the case may be, has little if any comment relative to aging and blindness. This is a very difficult problem for us to accept. We feel that the way to provide proper treatment to blinded veterans is to treat them when they need the treatment, not wait until they become a chronic situation and have to be placed in a nursing home or an extended care unit. The cost effectiveness then will be significantly reduced.

We are interested in the VA's looking at blindness as it is looking at some of these other areas. Medically speaking, blindness is a failure, and it is difficult for us to get the VA to do research because it is not glamorous like some of these things you have witnessed today. It is not the medical approach that is necessary. It's a rehabilitative approach. If we can keep blinded veterans, who are aged, independent and in their homes, it will save the VA a great deal of money. To date, we have been unsuccessful in getting the VA to understand that and to realize the cheapest way to provide assistance to blinded veterans is to keep them independent and in their homes and to provide research so that that can be done.

The rehabilitation programs the VA presently have are excellent for younger blinded veterans, and they provide good service to older blinded veterans, but they have not exercised research to undertake what is the best approach for older blinded veterans.

In addition to those service-connected blinded veterans who are becoming older, we have a large number of nonservice-connected blinded veterans eligible for treatment through the VA, and a larger number who are becoming blind because of the aging of the World War II population. The VA's present process for rehabilitation of blinded veterans will not and cannot cope with that problem. We need the VA to look on a research basis as to what aspects of aging and blindness can be overcome through rehabilitation programming and to have somebody do research in this area, which is not probably medical, but more of a sociological-psychological approach.

We feel this is the way the VA needs to go. We want the VA to do something about that process.

Thank you.

[The statement of George E. Stocking appears at p. 114.]

Mr. **Edgar**. Thank you very much for your statement.

Mr. Gorman.

STATEMENT OF DAVID W. GORMAN

Mr. **Gorman**. Thank you very much, Mr. Chairman.

Before summarizing my remarks, I would like to begin by extending to you and the members of this subcommittee the DAV's sincere and genuine appreciation for the interest you have shown in the VA's research efforts as evidenced by holding this series of three hearings on the VA's research programs.

As you are well aware, Mr. Chairman, the demand upon the VA health care system has been mounting steadily and will continue to do so through the balance of this century and beyond as America's veteran population, particularly the World War II veterans, continues to grow older. The number of veterans age 65 and older will grow from approximately 2.9 million in 1980 to over 9 million by the year 2000, representing approximately 34 percent of the then existing veteran population that will be over 65 years of age.

The Geriatric Research, Education and Clinical Centers represent, in our opinion, a vital component of the VA's efforts to address and meet the needs of the aged veteran. They serve to attract and develop superior staff in the field of gerontology and geriatrics and to advance and integrate research and educational achievements into the VA health care system. This, in turn, will form the foundation for future research aimed at delaying the age-related degenerative processes that make the elderly so vulnerable to physical, functional, and mental disorders.

As you know, Mr. Chairman, the VA's research program is comprised of three basic components: Medical research, which provides opportunities for basic science and clinical investigations; rehabilitation research and development, which is dedicated to improving the quality of life and the functional independence of physically disabled veterans; and health services research and development which places emphasis on research methods and data analysis strategies that are used within the framework of health services research. These include technology assessment, operations research, economics, clinical decisionmaking, clinical epidemiology, and program evaluation.

Mr. Chairman, it is the DAV's opinion that the VA is doing an admirable job regarding their research programs with respect to the aging, although the total VA research component received less than 2 percent of the total Department of Medicine and Surgery's budget in fiscal year 1983.

Fully recognizing the VA's achievements in research related to the aged veteran, Mr. Chairman, the DAV would nevertheless offer the following recommendations:

Funding for VA's health services research programs should be signficantly increased with an eye toward developing responsible alternative methods for meeting the needs and demand for care presented by the aging veteran population.

Second, given the fact that older veterans present a greater need for prosthetic and orthotic devices, as well as sensory aids and other devices, funding for VA's rehabilitation research and development program should be bolstered.

Again, Mr. Chairman, the DAV does commend the VA's medical research efforts directed toward the aging veteran. In our view, fulfillment of our Nation's obligation to its aged veterans lies within the VA's coordinated, medical, rehabilitation and health services research programs.

That completes my summarization, Mr. Chairman. I would like to thank you again for the opportunity of appearing.

[The statement of David Gorman appears at p. 119.]

Mr. **EDGAR**. Thank you very much for your statement.

Mr. Powell.

STATEMENT OF R. JACK POWELL

Mr. **POWELL**. Thank you, Mr. Chairman. It is a pleasure to be here at the last of the hearings, as we were here at the beginning of the hearings, and to have watched the progress as the Veterans' Administration and this committee have unrolled what is taking place in the VA research activity.

Much of PVA's testimony submitted here formally consists of a statement authored by Dr. George Hohmann, professor emeritus of the University of Arizona. Dr. Hohmann is a charter member of the Paralyzed Veterans of America who became paralyzed during the Battle of the Bulge in World War II. We had hoped he would be here today. However, he was unable to be here because of some of his own problems encountered with aging which perhaps leads to the enlightened self-interest of his statement.

Dr. Hohmann is I guess somewhat of a classic example of the situation with veterans benefits. He came back from World War II, was treated in the then Birmingham VA facility in California. He went to UCLA under the GI bill and obtained his Ph.D. from UCLA in 1955. He went to work as the staff psychologist for the Long Beach Spinal Cord Injury Center at Long Beach VA, worked there until 1962, when he became chief of psychology services at the Tucson VAMC, a position he held until his retirement in 1978.

Aside from publishing many articles and professional journals, he continues to teach on the faculty of both the departments of psychology and psychiatry at the University of Arizona.

George's words speak far more eloquently than mine would ever do, but as evidence of specific concern for the catastrophically disabled long term in conjunction with the aging process, he points out research evidence that indicates an incidence of malignancy 20 times greater among those with long-term spinal cord injury than among comparable age groups of individuals without spinal cord injury. He points out the growing incidence uniquely among SCI veterans treated for end-stage renal disease of amyloidosis, leading to an unusually frequent degree of cause of death. Most importantly, however, Dr. Hohmann draws attention to the VA's singular ability in conducting research on aging problems, specifically for SCI, but in general for Americans.

We have talked about a lot of things today and a lot of numbers have been brought up—the numbers of 3 million veterans over 65 in 1980, the number 9 million by the year 2000, two-thirds of the adult male population. That number doesn't end in 1990. As far away as 45 years from now there will still be twice as many veterans over age 65 in the year 2030 as there are today.

We talk about a number of other things that the Veterans' Administration has brought up. Ambulatory care visits are expected by the Veterans' Administration almost to double, up to 33 million visits a year by the year 2000. Extended care days will triple to approximately 150,000 veterans per day in extended care. Long-term care service needs will increase more than 50 times by the year 2000. So it is extremely important, Mr. Chairman, as you pointed out, that the "aging" aging report some time see the light of day.

Nursing home and domiciliary care alone is projected to increase from 40,000 beds today to well over 110,000 beds by the year 2000.

Also, it is important that we look at the mix of the veterans. Lou Harris' survey shows that 46 percent of aging veterans say that they will use the Veterans' Administration system within the next 10 years. Over 52 percent of the veterans seeking care at the Veterans' Administration are there because they can't afford health care or don't have private sector insurance.

We always talk about concern for budget deficits, and it is an important thing to do. But I think more importantly, as we look at research on aging, it is important that we keep everything in perspective. Whether we treat veterans in Veterans' Administration facilities, or whether we treat Americans somehow in some system, within the next 15 years we will have to come to grips with the question of what do we do with aging Americans. The opportunity to acquire the answers to best deal with that arises through the Veterans' Administration system, because they lead the curve on age and because we have the information to deal with them and isolate them into groups that allow us to determine methodologies for treating the larger portion of our population.

That's the thought I would leave with you, Mr. Chairman.

[The statement of R. Jack Powell and Dr. George W. Hohmann appears at p. 127.]

Mr. **Edgar**. Thank you very much.

Mr. Schwab.

STATEMENT OF DONALD H. SCHWAB

Mr. **Schwab**. Thank you, Mr. Chairman.

Due to the tenacious effort of the Honorable Margaret Heckler, who was then a member of this committee, and this subcommittee and the full committee, Public Law 96-330 authorized expansion of the GRECC's from 8 to 15. That was in 1980. It was not until fiscal year 1984 that any funding was made available for expansion, and two new GRECC's will be established, one in fiscal year 1984 and one in 1985. The need for these GRECC's is obvious. It has been justified, and the VFW has been critical of the slow expansion from 8 to 15.

Mr. Chairman, according to an article in the May 15 edition of U.S. Medicine, entitled "VA Aging Plan Shows Growth Needs," 30 Geriatric Research, Education and Clinical Centers should be established by 1990 and should increase by 60 percent the number of trainees over the current level. If we are to see such an ambitious undertaking through to fruition, Mr. Chairman, obviously there has got to be a substantial increase in the budget and personnel recruitment.

The cited U.S. Medicine article also quoted the Administrator of Veterans' Affairs as, besides needing 30 GRECC's by the year 2000, a 68-percent increase in hospital beds will be needed, with special geriatric evaluation units at each medical center. Outpatient clinics should be able to support 26 million visits with appropriate prevention and geriatric specialized services, and extended care programs must be increased with the appropriate linkage to non-VA community programs for the elderly.

Mr. Chairman, a price tag was placed on this of $42 billion in the article. That's a lot of money. But at this point I would state that in 1975 the VA portion of the Federal budget was 5.1 percent. It is now less than 3 percent. If the VA had 5.1 percent of the proposed budget for fiscal 1985, it would be about $47 billion. But you know and we know that the VA budget for medical care and research is inadequate. Your report to the Budget Committee, Committee Print No. 55, made this abundantly clear. The crux of the matter is necessary funding and personnel and we don't think the VA can continue to serve veterans, older veterans in particular, unless more funding and more personnel are made available.

That concludes my summary, Mr. Chairman.

[The statement of Donald Schwab appears at p. 146.]

Mr. **Edgar**. Thank you very much for your statement.

Before making a comment and closing the hearings, I would like to recognize the presence in the hearing today of Mr. Melidosian, who is the former Director of the Philadelphia VA Regional Office and Insurance Center. We appreciate his being here, and also his expertise on veterans' issues. He is teaching us how veterans of the VA age gracefully, but he also has been a great friend and helper in the number of ways in helping to shape VA programs over the years and we appreciate his presence here this morning.

Each of you have given a strong statement relating to the need to focus research on concerns of the aging veteran. Whether it is blinded veterans or whether it is World War I veterans, whether it is paralyzed veterans or disabled veterans or the general population of veterans at large, the need is there. Each of you have articulated that to help bring some focus to it.

I would hope that as you move out to your conventions over the next year, as you spend some time talking about the issues and trying to bring your membership up-to-date on what has been happening in Congress on the variety of issues, the health care issues and education, training, compensation issues that we have been dealing with, that you might speak to your membership about the hearings we have held dealing with research, the value that we have seen, as well as some of the needs financially.

Also bring them up-to-date on the issue of the "aging" aging report and also to do something specifically. Mr. Schwab talked about the dollars that are going to be committed to it if we are going to meet the needs. We have talked about the number of Geriatric Research Centers that are needed if we are to meet the needs. There is a great deal of work that has to be done if we're going to meet just some of the demographic changes that are going to occur. So I really look to you, as the veterans' organizations of America, to tell the story and to help communicate that story to your members and they, in turn, to the public at large.

We have to come back and ask for some specific request, whether it is the two additional GRECC's that we put in the budget this year, which probably should be three or four, or whether it is the need for a specialized service to be provided within the VA health care system to meet the need, or whether it is a specialized research program coming out of our hearings or coming out of our knowledge of particular areas of curiosity and concern that we are going to need to pursue over the next few years. We are going to need your help, and I am asking you, as people who have been following and watching these hearings, to give us that help so that Dr. Boren and others can begin to shape a research program and a response to geriatric and aging veteran needs that is adequate to meet the demography that we're seeing.

I appreciate your presence here. There are some members on both the Republican and Democratic side that have conflicting hearings. We do have on the House floor the immigration bill today, so many Members have been pulled in lots of different directions. But we do appreciate your presence today.

This hearing now stands adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

APPENDIX

Statement by
Congresswoman Olympia J. Snowe
before the
Veterans' Affairs Subcommittee on
Hospitals and Health Care

June 13, 1984

I want to thank you for this opportunity of coming before the Subcommittee today to discuss an issue related to neurological research -- that of the care of Alzheimer's disease victims who are also veterans.

Last year, in response to concern from Members such as myself, Congress appropriated millions of additional dollars to the National Institutes of Health (NIH) with committee report language stipulating that a priority be given to Alzheimer's disease research. More money has also been directed to the Veterans' Administration for research, and I am pleased that you are conducting this hearing today to explore the current "state of the art."

While these research initiatives are proceeding, however, I want to bring to your attention another critical, a more immediate problem -- that of the care of the victims who are today suffering from Alzheimer's disease. What treatment is available to veterans who have already contacted the illness?

From the reports I have received from some constituents and from across the nation, it is a pretty sorry picture indeed.

First, you might be interested in the following statistics associated with this illness:

-- It is the fourth leading cause of death among older persons, after heart attacks, cancer, and strokes.

-- It will claim one of six of us in our later years unless a cause and cure is found.

-- Presently, 3 to 4 million Americans suffer from Alzheimer's disease, including tens of thousands of veterans.

-- The illness runs from 3 to 15 years before the victim's inevitable death and is characterized by progressively debilitating memory loss, personality changes, and finally, total lack of control over bodily functions.

These statistics carry a grim significance for the Veterans' Administration. Experts predict that in 40 years there will be 43 million Americans 65 and over -- almost double today's elderly population. This is the age group most vulnerable to Alzheimer's disease, although many in their forties and fifties are victims.

Of course, the veteran population contains a significant percentage of the aging American population. Today there are nearly 4 million veterans age 65 and over. By 1990, there will be almost twice that number of veterans -- 7.3 million, and in the year 2000 there will be over 8 million veterans. In other words, I understand that by the year 2000 about 2 out of every 3 American males age 65 and over will be veterans.

Clearly, the Veterans' Administration will be facing a considerable challenge in the coming years to provide care for veterans with Alzheimer's disease, and clearly, the VA must play a major role in the nation's fight against this disease.

At the end of my statement, I have attached testimony written by a woman from Maine, Mrs. Marilyn Paige, whose afflicted husband is a veteran with a 25-year service record. I ask that her statement be included in the record after my own.

Mrs. Paige's story most movingly describes the situation that she, and many more like her, are facing as they care for spouses with this devastating illness. The VA facility in Togus, Maine is not run by heartless administrators. To the contrary. Mrs. Paige's statement describes how the VA has helped in some measure, but current law does not enable the facility to provide the necessary care to any extent over and above that which it is already giving. In fact, the Togus VA facility seems to have been more responsive in this family's case than are the reports I have received from other parts of the country.

Unfortunately, under current law, the VA has built in eligibility limitations that hamper its capacity to provide extended care for Alzheimer patients. As you know, first priority for admission to VA hospitals and nursing homes is given to those veterans with service-connected disabilities. Of course, this is entirely appropriate. Nevertheless, as pointed out in Mrs. Paige's statement, Alzheimer's disease begins very insidiously, often beginning years before it is finally properly diagnosed. Although her husband is now only 56, she has reason to believe he has actually suffered from the illness for the past 8 to 10 years, possibly before he retired from the service.

Veterans with nonservice-connected disabilities -- including those with Alzheimer's disease -- are admissable to "the extent that VA resources remain available", and if (1) they are age 65 or over, or (2) they are indigent.

What is happening around the country, however, is that when Alzheimer victims reach the point that institutional care is required, it is often difficult to place them in a VA facility because of their lower priority ranking, and because many VA facilities point to the fact that they do not have the personnel to care for these patients. This stituation is complicated further because the VA is not authorized to pay for care for nonservice-connected patients in community nursing homes for longer than six months.

Remember this is an illness that can take 15 years to run its cruel course, many of those years requiring institutionalization.

It is not my intention to convey the idea that the VA is not providing any care at all for Alzheimer patients. In fact, I understand some veterans with Alzheimer's disease are being treated -- and treated very well -- in certain VA hospitals and nursing homes. Where such care is given and in the research area, it appears the VA's Geriatric Research, Education, and Clinical Centers (GRECCs) have been very important. This research role should be continued and further expanded.

The real problem lies in the fact that the VA has no consistent policy concerning veterans suffering from Alzheimer's disease.

In a series of hearings conducted by various House Committees, including one I conducted in my own State of Maine, we have heard from families of Alzheimer patients which highlights this lack of consistent policy. Apparently, some VA hospitals do accept Alzheimer patients while others do not -- with no obvious reasons for the difference in policy. We also have been told that some Alzheimer patients who have been admitted to VA facilities have been asked to leave after only a short stay, or have been transferred to nursing homes where the family must bear the cost.

I understand from Mrs. Paige that her husband, who has finally been admitted temporarily to the Togus, Maine facility, may shortly be moved to a nursing home where the family must bear the cost. Mrs. Paige is currently receiving approximately $700 per month in veterans retirement benefits and $540 in state disability benefits. Nursing home expenses run from $1500 per month to $2000 per month. As a result, Mrs. Paige, who again I would like to remind you is only one of many caught in this devastating situation, will have to lose her only source of income as well as pay the rest of the monthly nursing home bill.

As with so many women in Mrs. Paige's age bracket, she has not worked outside the home as she was raising the children and moving with her husband throughout his army career. She must now sell every life insurance policy and give up every vestige of security for her own later years to become eligible for Medicaid coverage for those projected nursing home bills.

Neither Medicare nor most private insurance policies provide any significant amount of financial assistance to Alzheimer victims. Under Medicaid, nursing home care is covered, but usually not until the patient's family has been reduced to poverty -- which is what Mrs. Paige believes will happen to her. The VA's failure to implement a consistent and fair admission policy for veterans with Alzheimer's disease only exacerbates the severe financial and emotional strains confronting the families of such victims.

Mrs. Paige states that "as service people, we always believed if you became ill after you retired, 'they would take care of you.'" There appears to be a break in that unspoken contract between servicemen and women and their government. There appears to be exceptions to that understanding, a break in the trust such military people expected they had earned.

For this reason, last November I introduced legislation, H.R. 4273, which would lead to a consistent nationwide policy for dealing with Alzheimer patients who are also veterans. **First,** this legislation would authorize the VA administrator to ease the eligibility requirements for medical care by establishing a special priority category for Alzheimer victims and related disorders; **second,** lower the age of eligibility for such care if necessary; and **third,** require the VA to carry out a comprehensive program of screening, counseling, and providing information to afflicted veterans and their families. This measure currently has over 60 cosponsors, including some members of the Veterans' Affairs Committee. An identical bill, S. 2220, has since been introduced in the Senate.

I am well aware of the fact that this measure is not a perfect bill, but it does serve to focus on the issue; it does serve as a basis of developing the necessary national policy towards the care of such victims.

Perhaps we should also consider language that would set aside a certain percentage of VA beds for long-term care of Alzheimer victims. Perhaps another block of beds should be reserved for "special needs" determined by waiting lists and family situations. At the very least, we should consider regional plans for such care.

Another important note before I conclude my statement today. I well understand the difficulty of finding the trained personnel who will be required to care for Alzheimer patients. Such patients often wander during the course of their illness; many exhibit bouts of anger, and even violent behavior.

In recognition of the need for trained personnel in this area, at the same time I introduced the bill I mentioned before relating to the VA, I also introduced a measure to require the Commissioner on Aging to make a priority of those student grant requests specifying the study of the custodial and/or skilled care of victims of Alzheimer's disease and related disorders.

I am very pleased to report that this measure was incorporated in the body of the Older Americans Act reauthorization bill -- in both the House and, after I testified before the Senate Committee, the Senate version. The Senate has already passed its Older Americans Act reauthorization measure, and it is expected the House will pass its version next week. Whatever differences there are in these bills, there is already an agreement on this important provision.

This means that within a year or two, there will be more trained personnel to care for Alzheimer victims in our nursing homes, home health agencies, adult day care centers -- and yes, our veterans' hospitals. This means that within a year or two, veterans' hospitals will have the trained personnel so they might not turn away another Alzheimer sufferer as they do all too often now.

As our elderly population increases during the coming years, we can only expect increasing numbers of Alzheimer victims. We must now address the problem of providing care for these victims and support for their families. The VA must live up to the expectations of the military community who expect they will be taken care of "if anything happens."

I urge the Subcommittee to support my legislation -- and any other legislation -- that will assure that the VA will meet fairly its responsibilities to provide care and treatment for these victims.

STATEMENT OF MARILYN W. PAIGE
(Constituent of Congresswoman Olympia J. Snowe)

I want to thank you for the opportunity to make a statement on this legislation (H.R. 4273) dealing with Alzheimer's Disease - a disease affecting 3 to 4 million Americans today and is the 4th leading killer of adults.

My husband, who is 56, has had the disease perhaps 8 - 10 years. It's difficult to tell. This terrible affliction can start so insidiously that you are not sure at times if anything is really wrong. Symptoms can be very subtle when they first appear.

He was diagnosed in February, 1981. I was absolutely devastated and disbelieving. We went to another neurologist for a 2nd diagnosis which was the same. A short time later, during research prior to genetic counseling, I discovered that my mother-in-law had died of the disease. The doctors never gave us a name for her "mental illness." We were told that there is a small percentage of families that have a predisposition for Alzheimer's Disease. The experts are still not saying it is hereditary.

Six month later, after his diagnosis, my husband was fired from his job. Being at home wasn't too bad at first, even though he was frustrated because he wasn't going to work every day as usual. He kept saying he would get better and would return. There was a limited quality of life for us for awhile. We were able to do some of the things we enjoyed, and he was still able to do his yard work, although I began to notice many of the jobs he undertook were poorly done, which is typical of Alzheimer's victims. That June, after the diagnosis, he danced at his daughter's wedding as well as he ever had. Today, he is so unsteady he has great difficulty getting around. Gradually, the symptoms grew worse, but I managed to care for him at home, with one day a week spent at the day care center. By last year, I was afraid to leave him alone - he might fall or perhaps start to wander. Also, by last year, he was not able to communicate well, which was frustrating for us both.

My husband and companion of almost 30 years, for all practical purposes, had left me. Instead I had a big 2 year old who required constant supervision and help with all his daily needs. I started hiring a neighbor to come in whenever I had to leave the house. I was beginning to become quite stressed and fatigued, as I had to get up with him every night. (I neglected to say, that back in 1981, after his diagnosis and learning that it was familial in our case, I suffered a heart attack which was brought on by stress.) Last year, he started going to the 2-week Respite Care Program at the VA facility in Togus. He went once in September and then again in December.

By this time, my children were urging me to think about a nursing home, but I kept saying, "I'm not ready and he isn't either." I wasn't ready to let go - in fact I really wanted to keep him home until the end, which could be another 5 years or more.

During all this time, he had violent outbursts, perhaps once or twice a month, which I handled by leaving the room rather than having a confrontation which would serve no purpose, as Alzheimer's Disease victims are illogical and unreasonable. He threw things and many times threw himself on the floor as in a temper tantrum.

At the end of February of this year, I was due for another 2-week respite from the Togus facility. One morning, on February 15th, to be exact, I heard him fall in the bedroom. I went in to help him up. He couldn't comprehend. This man is 6' 5", weighing 200 pounds. I couldn't begin to lift him. I finally called the police and a patrolman came and was able to lift him to the bed. He was very shaky by this time, but I managed to dress him and assist him to the living room. He had to get up later that day and fell again. There was the same problem. This time a friend came in to help. That evening he refused to walk, and I again needed to call in help to get him to bed. That night, he was up 15 times as I was -- afraid he would fall again. The next day, he could hardly walk, and I had to pull him to his feet each time he had to get up. As I now had a heart problem, this physical stress was not really wise for me. If I became ill, what would happen to him? That night I was up 11 times with him.

The following day, in desperation, I called the social worker at Togus to see if they could push up my respite time. The bed was occupied. I started to cry, and I guess he took pity on me. He put me in touch with Dr. Whitney Houghton, head of the psychiatric ward. She said I could bring my husband which I did that day. The **MOMENT OF TRUTH** came. It dawned on me that I was beaten as I couldn't physically lift him. I was able to handle his outbursts, incontinence and daily care, but he was too big for me to move. I couldn't even move his legs as he resisted me so. It was impossible to keep asking neighbors to come in. A home health aide for 8 hours a day would cost about the same as a nursing home full time. I would still then be alone with him for 16 hours a day. I had asked the Veteran's Administration previously for help in paying for part-time help. They decided I should use the respite care more often. After he went to Togus on February 17th, my children and I talked; then I conferred with Dr. Houghton. There was a joint decision that this was the time to place him in a nursing home before he became too severe, or the nursing homes would refuse to accept him. I'm not sure if it's almost too late now, as his outbursts are more frequent. The staff is attempting to control these with medication.

The Togus facility was going to put him into a contract nursing home and pay for his first 6 month' care as allowed under the law. The morning of the day he was to be discharged from Togus, I received a phone call from them saying they could not pay for the first 6 months as he is a retiree, and they were billing the military for his care. The military, however, does not pay for nursing home care, and ny husband is not 65. He is still in Togus, and I'm waiting for them to decide what to do.

It's really ironic. Someone who was in the service a short time can receive the 6-months benefit with no problem. A retiree of 25 years, like my husband, has problems getting the benefit. I feel a man who gave all those years to his country, who loved the army more than anything, should be cared for by the VA rather than for only a few months. Additionally, who is to say that his illness was not "service-connected." There are many others such as I. Nursing home costs are exhorbitant -- they can impoverish families by the time they get through the entire nightmare. We have to live too. We watch our loved ones die by inches and are emotionally, physically and financially depleted at the end of this dreadful ordeal. As service people, we always believed if you became ill after you retired "they would take care of you."

Much is being learned about this endless nightmare called Alzheimer's Disease. Hopefully there will be a cure after we find the cause. In the meantime, **PLEASE HELP US.**

STATEMENT OF
JOHN A. GRONVALL, M.D.
ACTING CHIEF MEDICAL DIRECTOR
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

JUNE 13, 1984

Mr. Chairman and members of the Subcommittee:
I am very pleased to be here today to introduce the third and final presentation in this series of hearings on the medical and prosthetic research program of the Veterans Administration.

Our topic today is aging, but before we get into a discussion of the types of research being carried out by VA investigators, I think it might be useful to dispel some myths about the, quote, aging problem, unquote, and put the subject in perspective.

To begin with, I think it is time to stop thinking of aging as a problem. The swelling ranks of the over 65s represent the culmination of an incredible success story.

The fact that people are living longer is a tribute to the progress that has been made in the past 50 years: the medical research, improvements in health care, and lifestyle changes that have added more than 30 years to the lifespan of the average American since the beginning of the 20th Century.

What is more, people are arriving at 65 in pretty good health, for the most part. Indeed, in a recent survey, 63 per cent of Medicare beneficiaries described their health as "excellent" or "good." By contrast, only 12 per cent characterized their health as "poor." Only about 5 per cent of our elderly population is institutionalized.

Functional ability does decline with age, of course. The body is a finite mechanism, and, like other machines, it wears out. However, in the absence of disease, the decline can be gradual and old age can be a period of good health and sustained functional ability.

Unfortunately, this is not always the case. Changes in the body's internal metabolism can diminish resistance to certain diseases or increase the individual's vulnerability to certain degenerative conditions that can affect both physical and mental capacity.

Conditions and diseases that are found with increasing frequency in the elderly are: heart disease, cancer, stroke, degenerative joint disease, falls, urinary incontinence, hearing and vision impairment, and senile dementia.

This is where the challenge to medical research lies. Can we learn enough about the biological and psychological processes of aging to prevent or minimize these disorders and preserve mental and physical vigor as long as possible?

In terms of gaining the knowledge necessary to accomplish this goal, the principal areas of research are:

- studies of the aging process itself;
- the development of alternate modes of care; and,
- the development of treatment methods for specific problems (e.g., falls, incontinence).

The Veterans Administration has already begun to address this challenge and, as you will hear from today's witnesses, VA investigators are already exploring promising lines of research in all these areas.

The VA's active geriatric research program is a natural consequence of the fact that our patient population is growing older. More than 3 million American veterans (about 11 per cent) are over 65 years of age now, and this number will triple during the next 15 years.

The more we can learn about the aging process now, the better equipped we will be to prevent, or at least minimize, the strain that this increase will place on our health care resources.

VA interest in geriatric research crystallized in 1974 with the establishment of the Geriatric Research, Education, and Clinical Centers (GRECCs). By 1985, there will be ten GRECCs, and in addition to a balanced program of research, education, and patient care, each center focusses on a specific research area, such as neurobiology, behavioral disorders, depression and senility, or cardiopulmonary diseases.

One of the most significant contributions to come out of the VA geriatric research program in recent years is the Geriatric Evaluation Unit (GEU), in which elderly patients with remediable impairments are treated by a team of health care professionals whose goal is to reduce morbidity, improve functioning, prevent unnecessary institutionalization, and help the patient retain as much functional independence as is compatible with his or her condition.

The VA currently has 26 operational GEUs, with 15 more in the planning stage. Initial results indicate that patients treated in a GEU have fewer deaths and fewer placements in nursing homes or hospitals.
The concept of the Geriatric Evaluation Unit may well serve as a model for the nation in revolutionizing the treatment of the older patient, and you will be hearing more about them today from Dr. Itamar Abrass, of the Sepulveda, CA., VA Medical Center.

Other witnesses you will be hearing from today are the following:

Dr. Marguerite Kay, of the Temple, Texas VA Medical Center, and one of this year's Arthur S. Flemming Award winners, will discuss her efforts to identify and define the immunologic mechanisms responsible for the debilitative diseases of aging.

Dr. Gabe J. Maletta, Director of the Minneapolis VA Medical Center Geriatric Research, Education, and Clinical Center, will discuss current research efforts directed at the diagnosis, treatment, and prevention of dementias in the elderly.

Dr. John W. Rowe, Director of the West Roxbury/Brockton VA Medical Centers' GRECC, will discuss how the endocrine changes that occur with aging affect the health of older persons. He will also review VA efforts to improve our understanding of the causes of diabetes in the elderly.

Finally, Dr. Gwenyth R. Vaughn, Chief of Audiology-Speech Pathology at the Birmingham, Ala., VA Medical Center, will talk about and then demonstrate some of the health care delivery systems and assistive listening devices developed by the VA for veterans with communicative disorders.

Mr. Chairman, that concludes my formal statement. I will be pleased to answer any questions that you or members of the committee may have.

STATEMENT OF
MARGUERITE M. B. KAY, M.D.
ASSOCIATE CHIEF OF STAFF FOR RESEARCH
VETERANS ADMINISTRATION MEDICAL CENTER
TEMPLE, TEXAS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

JUNE 13, 1984

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the Veterans Administration's Research Program on Aging.

My name is Marguerite M. B. Kay, M.D. I am the Associate Chief of Staff for Research at the Olin E. Teague Veterans' Center in Temple, Texas.

As I am sure you are aware by now, the sixty-five and older sector of the American population is growing more rapidly than any other single age group. At the present time in Western countries, there are two basic approaches to caring for the elderly. The first approach, which is the easiest, is to assume that there is nothing that can be done to reduce the debilities associated with aging. Based on this assumption, long-term care units such as nursing homes are established and elderly people are admitted to these units. This is an extremely expensive approach, both in dollars and in the quality of life for the individuals who are placed in long-term care units. An inherent assumption in this approach is that disease is part of aging. This is not correct. The second approach, the one which I follow, assumes that aging can occur independently of disease. The thrust of this approach is to define the mechanisms responsible for the debilitative diseases associated with aging. If we know the cause, we can treat the disease. Another part of this approach is to find the primary (causative) mechanisms responsible for aging of an individual so that we can intervene.

Medicine has, by and large, treated symptoms rather than curing diseases. Part of the reason for this is that the technology was not available to treat basic causes. That is no longer true. I am sure that many of you are aware that an overwhelmingly rapid revolution has occured within the past ten years in basic medical related technology including genetic engineering. We now have entered a remarkable era where we actually have the opportunity to treat and cure disease if we know what causes the disease. For once, our medical technology has outstripped our knowledge. Unfortunately, the rapid, expedient approach that produces the technology cannot be used to produce the knowledge of the basic causes. Elucidation of basic causes takes painstaking effort that must usually be done on samples of proteins and such things that may constitute one one-trillionth of an ounce. However, without this knowledge our technologies are useless against disease. So long as we only treat symptoms and not diseases, the number of nursing homes and long-term care units and the number of us admitted to those units will continue to increase.

These observations emphasize the important role of basic research in aging, both in terms of quality of life of the individual and in terms of the potential economic impact.

Research into primary causes of aging at a cellular level reveals that changes occur within proteins or molecules as cells age. Changes in cell membrane molecules affect not only the ability of a cell to interact with other cells and its environment, but also the ability of subcellular components to interact within the cell. Thus, the primary affect of aging on cells and cellular systems, such as organs, is a disruption of inter-and-intra-cellular communication. Organ and systems failure is secondary to the failure of the highly evolved and differentiated communication networks. It is the highly evolved and highly differentiated character of these intricate networks that renders them vulnerable to the subtle disruptions such as those induced by aging.

At the present time, most of the investigators involved in research into the process of aging are studying an "organ" or a "system" that has "unique" aspects. Aging is obviously not a "unique" phenomena. It occurs not only in all animal organs and systems, but throughout the animal and plant kingdom. Thus, it seems to me, that greater progress might be made by stressing and investigating the common denominators that make the aging process "universal" rather than picking a minute differences that are merely the modification of primary causes at a tertiary, quartanary or, probably, far more distant level.

For example, the basic mechanisms resulting in the failure of intercellular communication within the central nervous system appear to occur, initially, at synapses which are areas where membranes are juxtaposed and the chemical messengers cross a narrow gap rather than circulating throughout the body on the way to their target receptors as in the case of the immune and neuroendocrine systems. There is nothing "magical" about a membrane at a synapse that makes it different from other cell membranes.

Since cells communicate with other cells through and at their membranes, and the end products of most cells is expressed at the membrane, membrane events are invaluable to our understanding of cells, functions, and the sum of cellular communication and integration that yields a human being, a dog or cat, a fish or bird, etc.

Characterization of the numerous changes each cell type within any system undergo with aging are superfluous and descriptive and do not reveal any insight into basic mechanisms. "Lots of cells do lots of things" and "lots of things change with age". If you were a Martian describing Homo sapiens to other Martians, you would not dwell on the idiosyncrasies of an individual, but on the factors common to a large number of Homo sapiens to convey a general idea of what this species is like. Similarly, investigations into primary causes of aging should describe the unifying factors rather than idiosyncrasies.

Investigations into molecular changes occurring during aging reveal that a terminal differentiation of antigen or protein, the senescent cell antigen, appears on the membrane of cells as they age. The appearance of this antigen marks the cell for destruction providing the other integrative circuits are functioning to receive, process, and execute the signal. Immunoglobulin (Ig)G autoantibodies in human serum attach to cells carrying the senescent cell antigen and initiate their removal by scavenger cells called macrophages. The senescent cell antigen

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was first observed on the surface of lymphocytes, polymorphonuclear leukocytes, platelets, embryonic kidney cells, and adult liver cells. The molecule from which the senescent cell antigen is derived has been on all cells examined including neural cells.

The senescent cell antigen is created by the breakdown of one of the major proteins in the membrane. This protein is responsible for the structural integrity of the membrane (i.e., it holds cells together), transport of vital substances, including water, into the cell, and is the "home" for a number of enzymes that are involved in generating energy for the cell. We have succeeded in identifying, isolating, and purifying this molecule. We have been able to determine that it is degraded with age. We further have been able to determine the point on this large molecule where the break occurs. We have yet to determine the cause of the break of this molecule. That is what we are working on now. When we can determine what causes the break of the molecule, we will have the cause of aging at a cellular, organ, and human being level. With that information, we will be able to use the high technology available today to prevent or delay that breakdown. The payoff is that we will be able to control the life-span of cells physiologically. This means that we can either increase the life-span of the cell or can decrease the life-span of the cell. Decreasing the life-span of a cell would obviously be helpful in treating such diseases as cancer.

In summary, the technology for curing disease rather than treating symptoms is already available. What is lacking is the knowledge of the causes of age-associated diseases at a molecular level. We cannot cure disease until we have this knowledge. Mr. Chairman, this concludes my formal statement. I will be pleased to answer any questions you or members of the committee have.

STATEMENT OF JOHN W. ROWE, M.D.

Director, Geriatric Research Education Clinical Center
West Roxbury/Brockton Veterans Administration Medical Centers
Boston, Massachusetts

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 13, 1984

Mr. Chairman and members of the Committee: My name is John W. Rowe, M.D. I am Director of the Geriatric Research Education and Clinical Center of the Veterans Administration Medical Center at West Roxbury and Brockton, Massachusetts and Director of the Division on Aging at Harvard Medical School. I am interested in the care of the elderly and conduct laboratory and clinical research on changes in endocrine systems with age. This research focusses on age-related alterations in the production of hormones and their effects on various organs in the body. In this testimony I will briefly review the importance of endocrine changes to the health of the elderly and will also comment on the very well-developed research program of the Veterans Administration in this important aspect of geriatrics.

The endocrine glands of the body include among others the pituitary, thyroid, pancreas, parathyroid, adrenal, and the gonads. The hormones produced by these glands play important roles in regulating many critical body functions. Changes in endocrine glands are an important aspect of aging for two reasons. Firstly, endocrine changes that occur with age in the absence of disease modify the capacity of elderly individuals to respond to stress such as acute illness and contribute to the increased vulnerability of the elderly to adverse health events. Secondly, endocrine diseases become increasingly prevalent with advancing age and are associated with substantial morbidity. Endocrinological studies of aging are currently being performed in six of the eight GRECC's established by the VA throughout this country as well as at numerous VAMC's that do not have GRECC's. This reflects the increasing commitment of the Veteran's Administration Research Service to aging-related studies in order to assist in our understanding and management of the burden of disease of the growing elderly veteran population.

With regard to the endocrine changes that occur with normal aging, it is very well documented that advancing age is associated with progressive alterations in the function of many glands that are important in maintaining normal body function, including the thyroid gland, the pancreas, and the gonads. While these aging changes are considered to be a normal concomitant of aging and thus do not represent disease states in themselves, they clearly put the elderly at increased risk of complications of surgery or acute illness. For example, under ordinary circumstances, normal older individuals have the same body temperature as their younger counterparts, but when exposed to extreme cold, older individuals are much more likely to develop dramatic, and often life-threatening, reductions in their body temperature than younger individuals. This problem, which is termed accidental hypothermia, each year accounts for numerous deaths in the elderly and appears to be related to age-associated impairments in the hormonal response to the stress of low temperature. I would like to focus my comments on the changes that occur in the pancreas with normal aging since they have particular relevance to a disease, diabetes mellitus, that is common in the elderly.

Older individuals are less efficient in utilizing sugar as a source of energy, thus resulting in higher blood sugar levels in the elderly than in their younger countrparts. Failure to take this normal hyperglycemia (or high blood sugar) of aging into account can result in an older individual being diagnosed as diabetic when they are actually just performing normally for their age on a sugar tolerance test.

The possible causes for this reduction in sugar metabolizing capacity with aging include alterations in diet, activity, body composition particularly increases in body fat and decreases in muscle, as well as deficiency of insulin, the major hormone reponsible for the metabolism of sugar, and decreased action of insulin on body tissues. Of these various possibilities, studies performed at several VAMCs including the GRECCs at Palo Alto, CA and at West Roxbury and Boston, MA, as well as the VAMC in Denver, CO, have identified the presence of an age-related resistance to insulin's action in normal elderly individuals. In addition, these studies show that this basic age-related insulin resistance is aggravated by the changes that occur in body composition, diet, and exercise with advancing age. Studies such as these which clarify the basic mechanisms underlying physiologic changes with age are critical since we must understand normal aging before we can proceed with a clear understanding of the differences between illness in healthy young and older adults.

The changes that I have referred to in the capacity to metabolize sugar are normal for aging individuals. Greater reductions than these can also occur and result in the development of the disease, diabetes mellitus, with which you are all familiar. Diabetes, which is basically a severe impairment in the capacity to metabolize sugar is associated with many complications and is the third leading cause of death in the United States and the leading cause of blindness. There are currently 5 million diabetics in the United States and fully one out of four of every new renal hemodialysis patient has kidney failure based on diabetes.

The number of individuals who are diabetic increases dramatically with age. One of every thousand individuals age 40 will become diabetic each year, while 6 per thousand will develop diabetes at age 70. Fully 7 per cent of individuals over age 65 are currently diabetic and the prevalence of diabetes rises dramatically with advancing age so that in the oldest age group, those over 85 years, (which also represents our most rapidly growing age group in the country) 17 per cent are estimated to have diabetes mellitus.

As with many other diseases, the treatment of diabetes is importantly altered with advancing age so that expertise in geriatrics, such as is being developed by the GRECCs within the VA, is an important component to the proper management of elderly diabetics. Just as children do not merely represent young adults, older individuals do not represent old adults, but have a different physiology and require different management of their diseases.

Currently, the research program of the VA is funding a large number of studies, both basic research studies and clinical studies aimed at increasing our understanding and improving our management of diabetes in the elderly. Examples of some of the basic studies include evaluations of the mechanism of the resistance of the cellular resistance to insulin in adult onset diabetes, studies of the changes that occur in diabetes in the insulin receptors, the molecules through which insulin acts on cells, factors affecting insulin secretion from isolated cells of the pancreas, and studies of the effect of diabetes on function of nerve cells. Clinical studies that relay importantly the impact of our understanding of the management of diabetes in the elderly veteran which are currently being supported by the VA research program include studies of stress and immune response in control of the complications of diabetes, studies of the effects of dietary composition on regulation of carbohydrate and fat metabolism in diabetic patients, studies of a variety of different medications in the management of the high blood sugar of diabetes, as well in the development of complications, studies of the psychiatric complications of diabetes and the proper mechanisms for the delivery of health care to the elderly veteran diabetic.

The VA has clearly taken the lead in developing academic research and educational programs in geriatrics in this country. Currently, the VA is the major trainer of new geriatricians in the United States. It is clear that, in the case of diabetes, the VA has developed and supported a two-pronged approach investigating not only the changes that occur in sugar and insulin metabolism with normal aging, but also the special characteristics of elderly individuals with diabetes mellitus, a severe impairment in insulin and sugar balance. This two-pronged approach will improve our understanding of the aging process and its clinical impact while at the same time advance our capacity to adequately care for the burden of illness of the rapidly growing elderly veteran population.

Mr. Chairman, this concludes my formal statement. I will be pleased to answer any questions you may have.

STATEMENT OF
GABE J. MALETTA, Ph.D., M.D.
DIRECTOR, GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTER
VETERANS ADMINISTRATION MEDICAL CENTER
MINNEAPOLIS, MINNESOTA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

June 13, 1984

Mr. Chairman and Members of the Committee:

I am pleased to have the opportunity to discuss with you today the topic of diagnosis of dementia in the elderly. My name is Gabe J. Maletta, Ph.D., M.D. My postgraduate training is in Physiology, Medicine and Psychiatry and I am presently the Director of the Geriatric Research, Education and Clinical Center (GRECC) at the Minneapolis V.A. Medical Center. I am also an Assistant Professor in the Departments of Psychiatry and Neurology at the University of Minnesota Medical School. I have been involved in the study of Gerontology and Geriatrics for more than 20 years and have published extensively in the area of the aging nervous system. I sit on many committees, boards and task forces that focus on aging from many directions, including clinical, educational, research and administrative interests. For example, I am a member of the National Board of Medical Advisors of the Alzheimer's Disease and Related Disorders Association, the Task Force on Psychiatric Services to the Elderly of the American Psychiatric Association and Chair of the Membership-Fellowship Committee of the Gerontological Society of America.

The continuing increase, both present and future, in the percentage of the population of the United States over 65 is well known. At the present time this population numbers approximately 26 million, or 12% of the population. Within the next 40 years, the numbers will increase to approximately 56 million, or 20% of the population of the United States. The Veterans Administration in some ways represents a harbinger or forerunner of this overall "greying of America" since, at the present time, the numbers of veterans over 65 already number approximately 3.3 million; by the turn of the century, a mere 16 years from now, the numbers will increase to a staggering 9.3 million. This tripling reflects all those veterans from WW II and the Korean Conflict who reach and surpass age 65 now and throughout the next several years.

Along with this increase in the number of elderly, there is a concomitant increase in the diseases which are more prevalent in this age group. For example, chronic diseases in general are seen twice as frequently in patients over 65 than in those under 65. Also, the frequency of many diseases of the nervous system increases with aging. Many of these nervous system diseases are characterized by an intellectual decline and deterioration and are referred to as the dementias. It is important to define properly the word "dementia" because of the large number of meaningless labels that are presently attached to people suffering from these kinds of diseases and also because of the myths that surround them. For example, the words "senility", "organicity", and "OBS" are meaningless because they have no diagnostic specificity and, therefore, no effective treatment plan can be mounted. One of the major myths surrounding elderly individuals with these diseases is the idea that intellectual deterioration is a "normal" development of the aging process, rather than an expression of nervous system disease as we understand it to be today. This can be seen clearly by the fact that although the numbers of elderly with dementing illnesses are very high, more than 2 million at the present time, with over half of these dementias caused by Alzheimer's disease, that's less than 10% of the total population over 65. Because the dementias are more prevalent in elderly individuals and due to the fact that this segment of the population is so rapidly expanding, there will continue to be a significant increase in patients with dementias over the next several decades. Therefore, it is critical to reinforce the fact that people with dementia are individuals suffering from disease. That needs to be well understood so that appropriate and effective treatment and, eventually, prevention may occur.

My definition of dementia is as follows and it may be reviewed from the handout that you have before you. Dementia is essentially an observed group of signs and symptoms characterized by a generalized deterioration that gradually takes place over a prolonged period, sometimes years, in cognitive or intellectual functioning. For example, a decrease in attention, perception, concentration, orientation, memory, judgment, word finding, and so on, may all be seen. It is important to note again that dementia is not a disease at all but is simply a group of signs and symptoms caused by a variety of different diseases.

I would like to make 3 main points during the course of this brief presentation. Number One: The dementias, as defined, are caused by a variety of diverse neurological and medical problems. Please refer to your handout entitled "Major Causes of Dementia." Number Two: Dementias are not simply a medical problem but must be considered as a multifaceted one, involving the so-called bio-psycho-social-cultural approach. The third point is that all presentations of unusual intellectual function or behavior in an elderly individual are not necessarily dementia. Let me elaborate briefly on each point.

Point #1: Dementias are caused by a variety of medical and neurologic problems. On your handout, which lists a large number of causes of dementia, I'd like you to focus on the first two - that is, Alzheimer's disease and multi-infarct dementia. Alzheimer's disease makes up approximately half of all dementias seen in the elderly while multi-infarct dementia, which is literally defined as a series of small strokes over time, make up approximately 25% of the dementias. As you know, the cause of Alzheimer's disease is not yet clearly understood, although research continues at the present time, not only in terms of cause but also in terms of management. All the rest of the diseases on this list make up approximately the other 25% of the causes of dementias in the elderly. It is important to point out that a dementing illness may be either progressive, static or remitting. That is to say, over time the intellectual impairment of a patient with a progressive dementia will get gradually worse; both Alzheimer's disease and multi-infarct dementia are progressive dementias. Another patient, also suffering from a dementia but with a different cause, may remain at the same level of intellectual dysfunction for many years, a so-called "static" dementia. The concept of a remitting dementia is similar to that which is called reversible dementia by some of my colleagues. An individual found to be suffering from a specific curable disease, for example, B_{12} deficiency or chronic hypothyroidism, which was causing a progressive dementia is treated. The dementia is then arrested, or remitted, at that point; the patient will get no worse and, in fact, may even get somewhat better. The point to be reinforced is that even though all individuals with a dementing illness present with a generalized deterioration of intellectual function, the cause of the generalized deterioration varies widely from one patient to another.

Point Two is that the dementias as a group should not be considered as just a medical problem, but also a multifaceted one. Now that we are aware that a large number of causes for the dementias exist, it must also be pointed out that individuals with these diseases do not live in a medical vacuum. Their psychologic, socio-economic, and cultural situation also must be considered -- a multi-faceted viewpoint. A good example of this approach are the nutritional dementias. It is certainly possible to become demented over an extended period of time by depriving an elderly individual of a needed nutrient, such as Vitamin B_{12} or thiamine. However, that elderly individual may be unable because of physical infirmities to buy food and, therefore, does not eat; or perhaps that individual may be too depressed to eat following the death of a spouse of 40 or 50 years several months earlier; or perhaps the individual does not have enough money to buy adequate food to eat; or perhaps the individual no longer smells, tastes or sees the food as well as when he or she was younger and food is, therefore, no longer very important; or perhaps a set of ill-fitting dentures or no dentures at all cause pain on eating, and so forth. The point is a simple one. When considering a medical problem such as the dementias, one must also consider the special psychologic, sociologic, economic and cultural problems that exist today with this elderly population which may precipitate or aggravate the disease.

The third and last point to make is that all presentations of unusual behavior in an elderly patient are not necessarily dementia. This involves a process known as differential diagnosis. In an elderly individual who is presenting with unusual behavior, one must think not only of dementia but also of different diseases that may present with similar signs and symptoms. For example, many of these other diseases are grouped under the term Delirium. These are diseases characterized by a rapid onset of symptoms. If you refer to your handouts, you will find a definition for delirium, as well as a table of "Major Causes of Delirium." Also, depression in an elderly individual may frequently be mistaken for a dementia. The reason for the mis-diagnoses is that the presenting signs and symptoms may look similar in all these diseases. Often, an elderly individual with a delirium may present with a generalized deterioration of cognitive function, similar in all respects to a presentation of dementia. A good history will reveal a rapid onset, and continued observation will demonstrate an intermittent alertness which makes the differentiation between a delirium and a dementia fairly easy, if one takes the time to look for it. However, the differentiation in an elderly patient between depression and dementia is much more difficult. Often, these depressed elderly individuals do not present in the typical manner of the younger patient, who exhibits a sad mood, tears, inability to sleep or eat and other somatic complaints, feelings of helplessness, hopelessness, etc. Frequently, an elderly depressed individual will present in what is known as an atypical fashion. He may simply sit in a corner staring at the wall and exhibit psychomotor retardation - a general slowdown of mental and physical activities. Problems with attention, concentration, memory and other cognitive measurements are frequently compromised in this patient, making it appear remarkably like a dementia. It is obviously important to differentiate between a dementia and a depression because the treatments are so different and the success of treating an elderly individual with depression is quite good. But first, one has to suspect depression and not automatically dismiss an older individual who is experiencing problems with cognitive functioning as being demented, because that frequently means no treatment at all.

Diagnosis is always important because of treatment issues. However, specific diagnosis is not essential in elderly cognitively impaired patients when considering initiation of treatment. It is important to note here that all dementias can be treated; they can't all be cured, but can be treated. A better concept, perhaps, is total management. Treatment, or management, may be subtyped into four major categories. First, there are disease-specific treatments. That means, if someone is diagnosed as having a dementia caused by a well-understood disease, for example, a pernicious anemia, then specific treatment with Vitamin B_{12} is obviously the one of choice. The second category is pharmacotherapy and/or psychotherapy especially for those patients with dementias that are caused by less-specific disease processes, for example, Alzheimer's disease and multi-infarct dementia. These treatments should be directed at specific target signs and symptoms caused by these diseases because the specific underlying causes of these diseases are not yet known. It is important to note here that these treatments need to be carried out in a dynamic, ever-changing manner as the disease progresses over time and the patient continues to deteriorate. Third, family education and involvement in treatment are extremely important in these elderly patients with dementia, especially the progressive diseases. As the patient continues to deteriorate and less can be done for him, the needs of the family or other care-givers are significantly increased. The last treatment category, in a similar vein to family involvement, involves consultation with all care-givers involved. This is essential in order to effect consistent, organized and, therefore, optimum treatment and suggests a multi-disciplinary rather than single discipline approach to carry out the best treatment of the patient with dementia.

To reinforce a major point about treatment of these patients, it should proceed even though a specific diagnosis may not yet be clear. One should treat the specific signs and symptoms seen. Some of the common ones are depression, anxiety, assaultiveness and delusional thinking. There are two reasons for this approach. First, with elderly individuals exhibiting unusual behavior, one frequently never has a clear-cut diagnosis. Mixed dementias and depressions are common in these patients, especially those who have spent much time, sometimes many years, in long-term care or other institutions with little sensory input or stimulation. Second, the diagnosis of dementia, especially Alzheimer's disease, frequently produces in the care-giver a mind-set of nihilism. That is to say, there is the idea that nothing can be done for this problem; therefore, there is no treatment given, except for, perhaps, over-sedating the patient so that he remains quiet and does not "disturb" anyone.

As dementia research in the V.A. and elsewhere moves forward looking for root causes, future treatments and prevention modes, present day patients with progressive diseases like Alzheimer's can be treated and managed at a variety of levels--medical, psychologic, socio-economic and so on. This comprehensive treatment must involve not only the patient, but also the family and other care-givers as well as society in general in terms of education, provision of support groups, and continued funding for basic and applied research.

That concludes my statement, Mr. Chairman, which was, of necessity, a brief overview of a very comprehensive and complex area. I will be pleased to answer any questions you or members of the committee may have.

CLINICAL FEATURES DIFFERENTIATING DEPRESSION FROM DEMENTIA IN THE ELDERLY

DEPRESSION	DEMENTIA
Clinical Course	
Family usually aware of dysfunction and its severity	Family often unaware of dysfunction and its severity
Onset can be dated with some precision	Onset can be dated only within broad limits
Clinical Behavior	
Patients usually communicate sense of distress	Patients may/may not appear unconcerned
Nocturnal accentuation of dysfunction uncommon	Nocturnal accenutation of dysfunction common
"Don't know" answers typical	Near-miss answers frequent
Marked variability in performance on tasks of similar difficulty	Consistently poor performance on tasks of similar difficulty

(Modified from Wells, 1979)

DEMENTIA

DEFINED AS A CLINICAL SYMPTOM COMPLEX CHARACTERIZED BY A GLOBAL DETERIORATION OF INTELLECTURAL FUNCTION, INCLUDING MEMORY, ATTENTION, ORIENTATION, JUDGMENT, IMPULSE CONTROL, ABSTRACT THOUGHT, WORD-FINDING AND CONSTRUCTIONAL ABILITY, SEVERE ENOUGH TO INTERFERE WITH SOCIAL/OCCUPATIONAL FUNCTION.

PERSONALITY AND BEHAVIOR MAY ALSO BE DISORDERED AND THERE IS NO CLOUDING OF CONSCIOUSNESS.

DUE TO CHRONIC DEGENERATION OF THE CEREBRAL CORTEX AND MAY BE PROGRESSIVE, STATIC OR REMITTING.

MAJOR CAUSES OF DEMENTIA

ALZHEIMER'S DISEASE

MULTI-INFARCT DEMENTIA (LACUNAR INFARCTS)

SPACE-OCCUPYING BRAIN LESIONS

- CHRONIC SUB-DURAL
- CHRONIC ABSCESS
- FRONTAL MENINGIOMA OR A METASTATIC LESION

MYXEDEMA (HYPOTHYROIDISM) OR OTHER CHRONIC ENDOCRINE CAUSES

PERNICIOUS ANEMIA (VITAMIN B_{12} DEFICIENCY)

CHRONIC ARSENIC, MERCURY OR LEAD INTOXICATION

CHRONIC HEPATIC, RENAL OR OTHER METABOLIC DEFICIENCY

CARBON MONOXIDE POISONING

DIALYSIS DEMENTIA

MAJOR CAUSES OF DEMENTIA

(continued -2)

NUTRITIONAL DEMENTIAS

- FOLATE DEFICIENCY(?)
- NIACIN DEFICIENCY (PELLAGRA)
- PYRIDOXINE DEFICIENCY
- THIAMINE DEFICIENCY (AMNESTIC SYNDROME)

ALCOHOLIC DEMENTIA

CHRONIC NORMAL PRESSURE HYDROCEPHALUS

DEMENTIA PUGILISTICA

NEUROSYPHILIS

OTHER INFECTIOUS AGENTS (VIRAL; TUBERCULOUS; CRYPTOCOCCAL)

SPECIFIC NEUROLOGIC SYNDROMES (INCLUDING WILSON'S, PARKINSON'S, CREUTZFELDT-JACOB, HUNTINGTON'S, PROGRESSIVE SUPRANUCLEAR PALSY (?), CEREBELLAR DEGENERATION AND MULTIPLE SCLEROSIS)

DIFFERENTIAL DIAGNOSIS OF DEMENTIA IN THE ELDERLY MUST INCLUDE:

DELIRIUM

DEPRESSION

PSEUDODEMENTIA

INTOXICATION

APHASIA

TREATMENTS OF DEMENTIA

I. DISEASE-SPECIFIC

II. THERAPIES

  A. PHARMACOTHERAPY

  B. SUPPORTIVE

  C. DIRECTIVE

  D. INSIGHT-ORIENTED

  E. REALITY

  F. REMINISCENCE

  G. ENVIRONMENTAL MANIPULATION

  H. BEHAVIOR MODIFICATION

III. FAMILY INVOLVEMENT

IV. CONSULTATION WITH CARETAKERS

DELIRIUM

DEFINED AS A DISORDER OF ATTENTION AND CONSCIOUSNESS, WITH ASSOCIATED DYSFUNCTION OF PERCEPTION, MEMORY, ORIENTATION, THINKING AND JUDGMENT. THERE ALSO MAY BE FREQUENT LABILITY OF AFFECT, SLEEP-WAKE DISTURBANCE, PSYCHOMOTOR ACTIVITY AND LOSS OF REALITY TESTING (MANIFESTED BY HALLUCINATIONS AND/OR ILLUSIONS). IT IS RAPID IN ONSET, HAS A FLUCTUATING COURSE AND IS REVERSIBLE IN CHARACTER. IT IS CAUSED BY ACUTE METABOLIC DISRUPTION OF THE BRAIN, AND RARELY LASTS LONGER THAN ONE MONTH.

MAJOR CAUSES OF DELIRIUM

DRUG TOXICITY (PRESCRIBED; STREET; OVER-THE-COUNTER)

- PSYCHOTROPICS (ESPECIALLY ANTI-CHOLINERGICS), BROMIDE, AND ANTI-PARKINSONIANS, INCLUDING L-DOPA
- DIGITALIS, DIURETICS, ANTI-HYPERTENSIVES, CORTICOSTEROIDS, DISULFIRAM.

CENTRAL NERVOUS SYSTEM

- HEAD TRAUMA
- SUB-ARACHNOID OR EPI-DURAL HEMORRHAGE
- INTRACRANIAL MASS LESION
- TRANSIENT ISCHEMIC ATTACK (TIA)
- MENINGITIS (ACUTE & CHRONIC)
- EMBOLI LEADING TO MINOR STROKE (CVA)
- SEIZURE (ICTAL OR POST-ICTAL)
- LUPUS VASCULITIS

MAJOR CAUSES OF DELIRIUM
(Continued -2)

CARDIOVASCULAR/PULMONARY

- ANEMIA (DIETARY OR GI BLEED)
- "SILENT" MYOCARDIAL INFARCTION IN THE ELDERLY
- "SILENT" PNEUMONIA IN THE ELDERLY
- ONSET OF ARRHYTHMIA
- CONGESTIVE CARDIAC FAILURE
- PULMONARY INSUFFICIENCY

METABOLIC AND ENDOCRINE

- DIABETES MELLITUS
- HYPOGLYCEMIA (ALSO NON-KETOTIC HYPERGLYCEMIA)
- HYPERGLUCOCORTICOIDISM (ALSO HYPO-)
- HYPOTHYROIDISM (ALSO HYPERTHYROIDISM)
- HYPERCALCEMIA
- LIPOPROTEIN DISTURBANCES

MAJOR CAUSES OF DELIRIUM

(Continued -3)

SYSTEMIC

- INFECTIONS, SYSTEMIC OR CNS (WITH OR WITHOUT FEVER)
- DEHYDRATION & ELECTROLYTE IMBALANCE
- BURNS, MULTIPLE TRAUMA
- ACUTE HEPATIC FAILURE OR INSUFFICIENCY
- ACUTE RENAL FAILURE OR INSUFFICIENCY (UREMIA)
- ACUTE PORPHYRIA

MISCELLANEOUS

- FECAL IMPACTION IN THE ELDERLY
- URINARY BLADDER DISTENSION IN THE ELDERLY
- WITHDRAWAL FROM ADDICTION TO ETOH, SEDATIVES, HYPNOTICS
- POST-OPERATIVE STATE (PARTICULARLY CARDIAC & EYE SURGERY)
- INTENSIVE CARE UNIT SYNDROME
- EXTREME ISOLATION OR FATIGUE
- HYPOTHERMIA
- POST-PARTUM STATE

STATEMENT OF
ITAMAR B. ABRASS, M.D.
CO-DIRECTOR, GERIATRIC RESEARCH
EDUCATION AND CLINICAL CENTER
VETERANS ADMINISTRATION MEDICAL CENTER
SEPULVEDA, CA 91343
BEFORE THE
SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

13 JUNE 1984

Mr. Chairman and Members of the Subcommittee:

My name is Dr. Itamar B. Abrass. I am the Co-Director of the Geriatric Research, Education and Clinical Center at the Sepulveda Veterans Administration Medical Center. My presentation will address the issue of geriatric assessment units and specifically the results of the geriatric evaluation unit at the Sepulveda Veterans Administration Medical Center.

For many years hospitals in Great Britain and several other European countries have used special inpatient geriatric units to offer the ill elderly a different approach to their care than that provided on the usual hospital wards. Most of these units use interdisciplinary teams and stress careful assessment, treatment, and rehabilitation for medical, functional and psychosocial problems. A few geriatric units have more recently been established in various parts of North America.

These geriatric units involve several distinct aspects of care usually not provided to elderly patients in standard hospital wards, e.g., comprehensive assessment (functional status; medical, psychologic and social needs), short-term rehabilitation, optimal placement, and arrangement for long-term follow-up.

Several non-experimental papers in the current literature indicate that these units seem to have beneficial effects on such outcomes as placement location, diagnostic accuracy, and appropriateness of therapy.

In June 1979, a 15-bed inpatient geriatric evaluation unit was established at the Sepulveda Veterans Administration Medical Center to provide comprehensive interdisciplinary evaluation and treatment of geriatric inpatients. Its four major functions include: 1) inclusive evaluation of a patient's physical and psychosocial problems and formulation of therapeutic plans by a skilled interdisciplianry team; 2) provision of short-term, goal-oriented therapeutic and rehabilitative care; 3) selection of optimal post-therapy placement and comprehensive follow-up in a setting most appropriate to the patient's needs and desires; and 4) continuing follow-up.

The geriatric evaluation unit at the Sepulveda Veterans Administration Medical Center is staffed by a full-time interdisciplinary geriatric health care team. Patients are admitted to the geriatric evaluation unit from other services at the Sepulveda Veterans Administration Medical Center. Most of them are transferred from medical and surgical services after the acute phases of their illnesses have stabilized; some are admitted directly from the outpatient department if they seem to have problems warranting geriatric evaluation unit admission but do not require admission to the services for acute illness.

Patients aged 65 or older whose medical, functional, psychologic and social problems interfere with their discharge home, are eligible for admission unless their condition requires more intensive care than is appropriate on an intermediate ward, or unless their prognosis for long-term improvement is too poor to warrant the investment of time and resources on the geriatric evaluation unit as defined by specific criteria.

The assessment and planning phase of the patient's stay on the geriatric evaluation unit lasts about one week. Following this first phase, the geriatric evaluation unit staff and consulting services provide the indicated therapeutic and rehabilitative services. This second phase takes approximately one month.

After discharge, patients are usually seen regularly in the geriatric follow-up clinic, by the same physician who cared for them on the geriatric evaluation unit.

There have been two major ongoing studies on the geriatric evaluation unit, both funded by the Veterans Administration Health Services Research and Development Service. One is a descriptive analysis of patient outcomes. The second is a randomized controlled trial comparing patients treated on the geriatric evaluation unit to identical patients being treated on other conventional services. The first study presents descriptive data for the patients admitted to the geriatric evaluation unit during the first four years of its operation. Of the 255 patients admitted, over two-thirds went home or to board and care or retirement homes, and about a fifth went to skilled nursing facilities.

Throughout the four years, about three-fourths of patients admitted to the geriatric evaluation unit were judged by their referring physicians to require long-term instututional placement, and most of these patients had already begun to undergo skilled nursing facility placement procedures.

When actual placements from the geriatric evaluation unit were compared with placements expected by physicians before transfer of the patients to the geriatric evaluation unit, it was found that over half of the patients were discharged to places of lower levels of care than had been expected to be necessary. Improvements in functional status paralled improvements in placement. Of the 210 patients who potentially could have shown improvements, almost two-thirds did improve in their functional status scores.

Many new treatable diagnoses were made on the geriatric evaluation unit, an average of just over three per patient. The mean numbers of prescription drugs and drug doses decreased by about one-third during a patient's stay on the geriatric evaluation unit.

In analyzing which patients derived the most benefit from the geriatric evaluation unit, we found that individuals over age 75 who were suffering from specific geriatric disorders (such as depression, dementia, postural instability, or urinary incontinence) or who required specific rehabilitative therapy benefitted more than younger patients or those with specific chronic unstable medical problems (such as congestive heart failure or pulmonary insufficiency).

The randomized study is still in progress, but preliminary outcome data are extremely favorable. The most striking has been a dramatically improved one-year survival for patients treated on the geriatric evaluation unit--about half of control patients died within 12 months of randomization vs. less than one-quarter of geriatric evaluation unit patients. Another major geriatric evaluation unit benefit has been a reduction by more than half in use of both nursing home days and acute hospital days in the year of follow-up. Both functional status and patient morale showed significantly more improvement in the geriatric evaluation unit population. Although the geriatric evaluation unit stay made the initial hospital costs higher, subsequent savings in acute hospital and nursing home days more than made up for the initial geriatric evaluation unit investment. In fact, using Veterans Administration cost estimates, geriatric evaluation unit patients actually saved the Veterans Administration about $5,000 per year survived compared to the controls.

These data indicate that a geriatric program such as the Sepulveda Veterans Administration geriatric evaluation unit can have significant positive impacts on a targeted subgroup of frail elderly patients, beyond that achieved by usual medical care.

Mr. Chairman, this concludes my formal statement. I'll be pleased to answer any questions you or members of the committee may have.

STATEMENT OF

GWENYTH R. VAUGHN, Ph.D.

CHIEF OF AUDIOLOGY-SPEECH PATHOLOGY

VETERANS ADMINISTRATION MEDICAL CENTER

BIRMINGHAM, ALABAMA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

June 13, 1984

Mr. Chairman and Members of the Committee:

My name is Gwenyth R. Vaughn, Ph.D. I have been Chief of Audiology-Speech Pathology at the Veterans Administration Medical Center in Birmingham, Alabama, for the past seventeen years. For ten of those years, I was the principal investigator for four VA-sponsored Exchange of Medical Information (EMI) projects. These EMI projects were dedicated to the development of health care delivery systems and assistive listening devices for veterans with communicative disorders.

Presently, I am the principal investigator of a three-year research project supported by the VA Rehabilitation Research and Development Service. This project is entitled "Efficacy of Remote Delivery of Aphasia Treatment by TEL-Communicology." TEL-Communicology is a term I devised to describe the delivery of services by telephone to veterans with communicative disorders. The on-going Rehabilitation Research and Development project compares the efficacy of clinician and computer-assisted telephonic delivery of an aphasia treatment program with the traditional Face-to-Face delivery of services in a clinic. Aphasia usually results from a stroke or head trauma. These victims may have multiple communicative problems such as the inability to speak, to understand what is said to them, or to read or write.

TEL-Communicology can provide quality care for veterans (1) who are unserved or underserved because they reside in areas remote from audiology and speech pathology services, (2) who are unable to travel because of other health problems, or (3) who need frequent, intense, or long-term care. Telephonic delivery of services to communicatively impaired veterans can save the Veterans Administration millions of dollars in travel costs.

The Rehabilitation R&D project is essential to the establishment of whether TEL-Communicology is better than, equally effective, or nearly as effective as Face-to-Face delivery. This project can be instrumental in the evaluation of whether telephonic health care delivery can make quality care available, accessible, and cost-effective to the Veterans Administration.

Prior to TEL-Communicology, health care delivery to communicatively impaired veterans has been facility-centered. Veterans have had to come to a medical center or an outpatient clinic; fee-based speech pathologists and audiologists have had to be sent to nursing homes or domiciliares. Although TEL-C is not designed to replace Face-to-Face care, it can provide the supplementary sessions required for quality care.

TEL-Communicology consists of two types of delivery: (1) clinician-assisted, a procedure in which the speech pathologist telephones the patient and administers supplementary treatment and evaluation, and (2) REMATE computer-assisted, a procedure by which a configuration of computers located at the Birmingham VA Medical Center can telephone veterans nationwide and administer drill sessions. REMATE stands for "REmote Machine-Assisted Treatment and Evaluation." The REMATE computer system employs voice, teletypewriters, and Touchtone$^{(R)}$ telephones to communicate with patients. The REMATE computer system receives responses in the same three modes.

The REMATE computer is programmed to (1) evaluate the answer given by the patient, (2) determine the length of time the patient takes for each response, and (3) report the number of errors made on each query. These data are sent by telephone to terminals at VA Medical Centers in which speech pathologists and audiologists are using the REMATE delivery system. Upon completion of the Rehabilitation R&D project, REMATE will be programmed to receive more sophisticated information, thus making further research possible in the areas of clinical, rehabilitative, and delivery system effectiveness.

During the VA one-day Annual Census, 23.4 percent, or 21,300 veterans, were identified as requiring services for speech disorders. Seventy percent of the veterans in the VA outpatient clinics, and ninety percent of those in nursing homes had hearing problems. As the veteran population ages, the percentages of hearing and speech problems will increase.

In terms of cost-savings, TEL-Communicology can make a substantial impact on the VA travel budget. For example, the average distance a veteran at the VA Medical

Center in Birmingham has to travel to receive treatment for a communicative disorder is 170 miles. The cost of this travel has a significant impact on the Birmingham Medical Center budget. These costs become even more significant when travel must be provided for veterans with speech and hearing problems who must travel to the other VA Medical Centers and Outpatient Clinics throughout the country.

TEL-Communicology can provide supplementary treatment, evaluation, and rehabilitation services. Surveys and follow-up calls can provide outreach services. TEL-C can be used with veterans who are patients in large VA Medical Centers, in outpatient clinics, nursing homes, domiciliaries, and hospital-based-home-care programs.

Communication is one of the most important and most complex of human activities. The ability to communicate forms a basis for quality care and the quality of life. Cancer, stroke, and hearing loss can impair the individual's optimal personal, social, educational, vocational, clinical, and recreational performance. The results of the VA Birmingham Rehabilitation Research and Development Project will provide the evaluation of an innovative health care delivery system that is needed to bring service to both veterans and non-veterans who suffer from communicative disorders.

Mr. Chairman, this concludes my formal statement. I'll be pleased to answer any questions you may have.

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MICHAEL BILIRAKIS, FLA.
NANCY LEE JOHNSON, CONN.

July 31, 1984

Honorable Harry Walters
Administrator of Veterans' Affairs
Veterans' Administration
Washington, D. C. 20420

Dear Mr. Administrator:

As you know, Dr. Gwenyth R. Vaughn, Chief, Audiology-Speech Pathology at the VA Medical Center at Birmingham, Alabama, presented testimony to the Subcommittee on Hospitals and Health Care on June 13, 1984 and demonstrated the use of TEL-Communicology (TEL-C) within the Veterans' Administration. The Subcommittee was extremely impressed by this new supplementary treatment as one way to reduce the cost of patient care without compromising effective service.

As a result of the impressive testimony and demonstrations, I believe that the TEL-C system should be expanded but only if the means may be found, apart from the normal budget process, to improve the system's already favorable cost/benefit ratio. As a result of the hearing, my staff has conducted preliminary discussions with various telephone companies, including AT&T, to ascertain if discounted services and/or equipment could be donated or provided to the Veterans' Administration to expand the program.

It appears that preliminary discussions are reaching a productive stage, and I wanted to advise you of our progress. I believe it would be helpful, at this point, to arrange a meeting between the Subcommittee staff, appropriate VA officials, and the telephone companies so that we may further develop this concept.

I appreciate, as always, your attention to this matter. We look forward to working with you.

Sincerely,

BOB EDGAR
Chairman, Subcommittee on
Hospitals and Health Care

cc: Dr. John Gronvall

STATEMENT OF

THE VETERANS OF WORLD WAR I OF THE UNITED STATES OF AMERICA, INCORPORATED

BY

HERBERT M. HOUSTON
LEGISLATIVE DIRECTOR

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

June 13, 1984

Mr. Chairman, and Members of this Distinguished Subcommittee, we wish to thank you for the invitation to appear before you and present to you the thinking, and views of the membership of the Veterans of World War I of the United States of America, Incorporated, pertaining to Hospitals and Health Care.

My name is Herbert M. Houston and it is my pleasure and privilege to serve as Legislative Director of the Veterans of World War I of the United States of America, Incorporated, and of the Ladies Auxiliary of the Veterans of World War I.

For the information of the Members of the Committee who may not have seen me in these meeting rooms over a period of the past two decades, please permit me to give you a brief summary of my experiences so that you may be able to see that I have some knowledge of the subject of this Hearing.

I am a veteran of World War I. It was my privilege to be in the first convoy of troops which embarked for Europe in the A.E.F., landing in St. Nazaire, France, 26 June 1917. After six months of guard duty in that Port City on the docks, we were sent inland for intensive training with the French Army for two and one half months, then entered the trenches in the Verdun Sector of the front with the French Army March 17th, 1918, where we learned the rigor of trench warfare.

Just out of high school I enlisted in the United States Marine Corps for four years. With the exception of the six months guard duty on the docks in St. Nazaire, my first year was spent in training, a part of this training was in the trenches. The most rigorous of this was in wire repair details and scouting parties.

I was in the Fifth Regiment, Fourth Brigade, U.S.M.C. in Brigade of the Second Division, U. S. Army. I had the privilege of serving under the only Marine Corps General, to Command an Army Division, at that time. I had the distinct honor and high privilege of serving in the Brigade of the Division who had the enviable record of capturing more prisoners, advanced further into enemy territory, spending the longest time on the front lines in combat. They captured one-fourth of the prisoners taken by the American Expeditionary Forces, suffering one-tenth of all the casualties. They won more decorations than any other Division in the American Expeditionary Force and at one time, fought for 56 consecutive days without rest, the longest period of time for any American unit. It was in Belleau Wood in hand-to-hand combat that the Marines stopped the Germans and earned the nickname of "*Devil Dogs*" which is a symbol of pride to anyone who ever served in the U. S. Marine Corps. It was an example of gallantry seldom equalled in the history of warfare, and never excelled, before or since in the history of this nation.

I have taken this time and gone to this length relating historical events in which I have been a part. I was there and do not obtain my concept of the need of the aging veterans of World War I from books or folklore. I have dealt with the reality of war excessively in my statement because we are considering Veterans' need for hospitalization and the Care of the health of the aging Veteran. The Veterans of World War I have presented statements before numerous studies on the Aging over a period of years; There was the White House Study on the Aging, the Congressional studies of Problems of the Aging in the House of Representatives, Hearings before the Subcommittee on Government Operations of the 92nd Congress, 1971, Hearing before the Committee on Veterans' Affairs United States Senate, October 29, 1979, on Veteran Senior Citizen Health Care Act of 1979.

During each of these hearings on the Problems of the Aging and Health Care of the aging, Veterans Organizations, Members of the Congress, the House, and the Senate, gave exhaustive statements regarding the aging process of the human (humanus L.). With the exception of the testimony of the Veterans Organizations, each of the other individuals and/or panels of specialists, in our judgement failed to take into account all of the extenuating factors conducive to the deterioration of the existing aged. They do not fit into the same mold. The human is a biological product and even though life may be started by placing an egg and sperm in a test tube, when mind is added to the new being, no two beings are alike.

The conclusion of previous aged studies would indicate that all aged could be treated by the same formula, which is contradictory to human behavior, and as a result, we have the same problems in this decade we had in the last, and shall have in the future, unless we recognize the need and treat it realistically.

The Veterans of World War I are concerned in the problems of the aged as a national challenge. However, they are more concerned in the plight of the veteran of the first World War, for reasons to be given later. We think of three instances in the annals of America's recent wars which have tested the moral fiber of America's guardians of the peace, which stand out above all the rest. The Brigade of Marines in Belleau Wood, in World War I; the siege of Corregidor Island after the surrender at Bataan, followed by the Death March during World War II; the G.I.s and Marines floundering in the bottomless pit called Vietnam, because world politics would not give them a chance to break out and win their war. Experiences like these test mankind's soul, the participant of anyone in combat who survives the living Hell, like the three mentioned, strains the physical, mental, and moral being to the ultimate and is a Breed-apart and should not be classified in their aged years on the par with their peers in years.

The Veterans of World War I have been from the date of their discharge from the service in the military, disadvantaged in two categories. In the first they were and are until this day, America's only war veterans who were not provided readjustment assistance or pension after their discharge to enable them to adjust to civilian life after their service in a war. And, secondly, the veterans of World War I were and are, the only veterans of America's wars who were the victims of America's greatest Depression. With the exception of the service-connected who were eligible to qualify for an Educational or Vocational Training Program (comprising 260,000 plus), the rest of the more than four million were discharged, and evidently forgotten, as if they were expendable. It was up to the individual veterans whether they could swim or drown in a society where more than 10,000,000 were unemployed and no jobs for any of them.

Only a small percentage of these millions of veterans who were more privileged than the mass, were able to continue their education and prepare themselves for future life. The greater majority were unable to finish their education, or to learn a craft whereby they could provide for their family. The government could have provided readjustment assistance, but it did not. The excuse was there was not enough money. It was a case of priorities for the amount of money available under the Gold Standard. It was either take care of the needs of the veterans who won the World War, or adhere to the wishes of the Banking industry and loan monies to the foreign governments. The priority was for foreign loans and only Finland ever paid their loan in full. The other nations still owe part of theirs, which with accumulated interest is as much or more than the original loan. This judgement on the part of the government deprived a generation of veterans of their future potential in life.

It is because of this record of history Mr. Chairman, the Veterans of World War I feel justified to continue to appeal for consideration of the few remaining members of the Army of 1917-1918, for special legislation.

We notice among the subjects scheduled for this hearing are; "alternative out-patient services". This is a vital subject among World War I Veterans. The Veterans Administration Hospitals, Nursing Homes, and Out Patient Clinics, are the finest in the world. In the judgement of the Veterans of World War I, it would be a sad mistake to seek alternative methods of doing a job when the one now in use is the best we have ever experienced.

The veterans of the first World War worked diligently in an effort to secure the Veterans Administration and the V.A. Hospital, Out Patient Clinics, and nursing homes, because they remember what conditions were like in the early days. To listen to the power Brokers and revert back to the methods of contracting out to civilian agencies any of the services of the Veterans Administration would, in our judgement, be like trading our automobiles for horses and buggies. The thought of subjecting the treatment of battle field casualties to individuals without any knowledge of warfare or its victims would be contrary to medical progress.

The Veterans of World War I are deeply grateful to this Subcommittee for starting the legislative wheels into action that resulted in the enactment of Public Law 96-151. This Act provides Out Patient Care which enables the World War I veteran to stay in his home for needed treatment at less cost to the government and better therapeutic care for the patient than being transplanted to a hospital away from the home environment for the common ailments of age. We sincerely hope its services shall not be curtailed, as soon as funds are available, to add Dental care to the provisions of care. The available funds for the average World War I veteran are not adequate for needed dental care. This deficiency impairs the general health of the veteran and at the age of the WWI veteran, there is no hope of additional income to meet his needs unless it is provided by government.

The Veterans of World War I are faced with criticism today by friends who say they are foolish to continue to ask for an entitlement from the Congress, for it would not be in the interest of modern day politicans, and that the old soldiers do not have political clout. Our reply to them is that we have more than political clout. We have honor and only seek justice and fairness among veterans entitlements. And having been denied readjustment entitlements upon being discharged in 1919 and 1920, and the veterans of the 40's, 50's, 60's, 70's, were provided rehabilitation an advantage above and beyond anything the WWI veteran received, some substitute benefits are due the WWI Veteran as a matter of principal, and justice. So the Veterans of World War I of the U.S.A., Inc., feel it is a duty to seek substitute benefits in lieu of the rehabilitation entitlements other veterans have and are receiving, thereby bringing some semblance of equity of benefits of America's veterans of different wars.

We wish to express again our sincere appreciation for the privilege of appearing before you, to express our grateful appreciation to your consideration of our desire to express our views.

"Semper Fidelis"

Herbert M. Houston, Director
of Legislation of
The Veterans of World War I
of the U.S.A., Inc.

BLINDED VETERANS ASSOCIATION
1735 DESALES STREET NORTHWEST • WASHINGTON, D. C. 20036 • (202) 347-4010

TESTIMONY OF DR. GEORGE E. STOCKING
NATIONAL LEGISLATIVE COMMITTEE CHAIRMAN
BLINDED VETERANS ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE HOUSE VETERANS AFFAIRS COMMITTEE

JUNE 13, 1984

Chairman Edgar and Members of the Subcommittee:

I am very pleased to appear before this subcommittee today on behalf of the Blinded Veterans Association. As you know, the Blinded Veterans Association is chartered by the United States Congress, and we are the only veterans organization whose sole concern is the welfare of blinded and visually impaired veterans.

The BVA applauds the efforts of this subcommittee and its staff for its series of oversight hearings in recent months. We are especially pleased to have this opportunity today to discuss what we consider to be the single most fundamental challenge confronting the Veterans Administration--the aging of the veterans population and the VA's geriatric research efforts.

In recent years, it has not been possible to watch your television or open a magazine or newspaper without some mention of the graying of America's population. Few of these programs or periodicals mention that the veterans community is aging at a much more rapid pace than the population at large. Of course, all of us are familiar with the demographic reports from the VA. It is these reports which have spurred the VA to give serious consideration to the problems of aging veterans and the adequacy of medical care services to meet the increasing demand.

CHARTERED BY THE CONGRESS OF THE UNITED STATES

I am proud to appear before this subcommittee today because, like the VA, the BVA also has been working to get its house in order concerning the issue of aging. We have been working diligently within the past year to consider the impact of the aging process on our constituents. We have been attempting to make an assessment of the adequacy of VA services to meet these needs. This assessment process is not yet complete, but it is a process which has begun and which will continue.

Although I do not want to take the time of this subcommittee today to detail our efforts, I want to inform you that we are in the process of compiling information which could be very useful to this subcommittee's future efforts in any discussion of aging. We have requested (in writing) the Chiefs of VA Blind Rehabilitation Centers and Clinics to assess the impact of aging on blinded veterans, and we have written to each higher education institution which has a graduate program in blind rehabilitation or orientation and mobility 1) asking information on any research being conducted at the college or university; 2) encouraging them to continue any research efforts; and 3) offering to sponsor graduate research.

This hearing today is designed to assess the VA's research efforts related to aging. I am here today to speak about the VA's research efforts related to aging and blindness--a specialized area which the VA should take the initiative to address.

Very little has been done either in research or formal planning to address the problems of the aging blind in our society. This is true of the VA as well. Of the more than 500 geriatric projects which have been approved in recent years, only five have been related to blindness, visual impairment, and/or blind rehabilitation. We believe this is a very serious deficiency which will impact on blinded veterans today as well as those veterans who lose their vision--either partially or totally--as a result of getting older.

When I speak here today about the specialized needs of blinded veterans, I refer not only to those veterans who because of their blindness today are members of the BVA or qualify for membership in the BVA. Loss of vision or seriously impaired vision are the primary characteristics of an aging population. It is also the loss of vision which can contribute to decreased mobility in an older individual. With the loss of mobility comes an increased incidence of accidents and other health problems and a greater sense of isolation and uselessness.

Clearly, the VA should take the lead in funding such special research projects. One vehicle for this would be the dedication of one Geriatric Research Education Clinical Center (GRECC) to blindness, visual impairment, and rehabilitation concerns. Overall, the BVA is very pleased that the VA has renewed its interest in the Centers and the concept of the Centers as a prime vehicle to address the problems of the aging veterans population. The commitment of a center to blindness or vision-related research would provide the means for the VA to consider the special needs of visually impaired and blinded veterans on an ongoing basis. Such a center could concentrate its energies not only on aging related medical eye research, but on research related to prosthetics and sensory aids for blind and low vision patients. The center also could foster a model for staff training of those who will work with older blind and older visually impaired veterans. And as important, such a center could provide the means for the VA to establish an internal and ongoing assessment process of the geriatric needs of the blinded veterans population, especially as related to rehabilitation and daily living activities.

We believe that the lack of geriatric research activities (and other types of research as well) is due to the fact that blindness is not viewed as a medically-oriented disorder in an agency which is dominated by traditional medical researchers or doctors. Although there are some medical conditions which lead to blindness and are age-related, blindness and vision impairment present a rehabilitative need, not always a medical one. We believe there is a professional bias against such research and that such research does not seem worthy of financial investment. Obviously enough, research can only be conducted if a professional has an interest in conducting such research. Yet, the type of research proposal which would be submitted to conduct appropriate research related to blindness or visual impairment is not likely to receive favorable attention. It would be evaluated by traditional medically-oriented researchers or doctors. The criteria alone could be sufficient to reject the research proposal on the basis of limited results. No researcher, for example, is likely to present a proposal or grant application suggesting a cure for all blinded veterans.

This situation puts more pressure on the VA to initiate research projects and search for researchers who would be interested and capable of conducting blindness-related geriatric research. We believe such individuals exist. We hope that we can work with the VA in this area, and we hope that the information we receive from graduate schools on such research will prove helpful to this subcommittee and the VA.

Like everybody else in the veterans community, the BVA is eagerly awaiting the Geriatric plan which is scheduled to be released soon by the Veterans Administration. We applaud VA Administrator Harry Walters for his decision to marshall the VA's forces to conduct an assessment of the VA's capacity to respond to the aging dilemma. We have met with VA officials concerning the report telling them of our hope that the report will consider the specialized needs of the blind. We have not yet had an opportunity to review this report; but we look forward to doing so in the very near future. We would also encourage this subcommittee to hold a special hearing on the report when it is released and time has been made available to review its recommendations. Our previous meetings have indicated that the report will not deal in any significant way with blindness or visual impairment, and, if necessary, we would like to address this issue at such a hearing.

I want to conclude by taking a brief moment to thank this subcommittee and its chairman, Representative Robert Edgar, for the opportunity to present these views today. I will be very happy to respond to any questions you might have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
JUNE 13, 1984

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 877,000 members of the Disabled American Veterans, I want to thank you and the members of the Subcommittee for allowing us this opportunity to discuss the Veterans Administration medical research programs on aging.

Mr. Chairman, before proceeding with the text of my testimony, let me begin by extending to you the DAV's sincere and genuine appreciation for the interest and concern you have shown in the area of the VA's research programs. You are to be commended for conducting this series of three hearings dealing with the VA's research efforts--the first, on April 26, 1984, when testimony was received regarding VA research efforts on neurological diseases, followed on May 8, 1984, when testimony was received relative to prosthetic and rehabilitation research and, finally, today's hearing during which the VA's efforts in research concerning the aging veteran will be highlighted.

As you are well aware, Mr. Chairman, the demand upon the VA health care system has been mounting steadily and will continue to do so through the balance of this century and beyond as America's veteran population--particularly World War II veterans--continues to grow older.

The number of veterans age 65 and over will grow from 2.9 million in 1980, to approximately 5 million in 1985 and 7.2 million in 1990. It is projected that by the year 2000, over 9 million veterans--or roughly 34% of the then existing veteran population--will be over 65 years of age.

In addition to the 172 acute care hospitals located throughout the United States, the VA has embarked upon program expansion in a number of areas intended to be responsive to the overall needs of the aging veteran. A large proportion of intermediate care beds are now occupied by older veterans with chronic debilitating problems requiring skilled nursing care. In addition to intermediate care, there is a full spectrum of institutional and non-institutional care in the VA. The programs are characterized as follows:

VA Nursing Home Care. The nursing home care units located in VA medical centers provide skilled nursing care and related medical services, as well as opportunities for social, diversional, recreational and spiritual activities. Nursing home patients typically require a prolonged period of nursing supervision and rehabilitation services to attain and maintain optimal function.

Community Nursing Care. This is a contract program for veterans who require skilled or intermediate nursing care to assist them in making the transition from a hospital to the community.

VA Domiciliary Care. Domilciliary care in VA facilities provides necessary medical and other professional care for eligible ambulatory veterans who are disabled by age, disease, or injury and are in need of care but do not require hospitalization or the skilled services offered in a nursing home setting.

State Veteran Homes. The VA relationship to State Veteran Homes is based on two grant programs--Per Diem and construction. The per diem program enables the VA to assist the states in providing direct hospital, nursing home and domiciliary care to veterans eligible for VA care. The other grant program provides VA assistance in the form of direct funding for construction of new state domiciliary and nursing home care facilities as well as the expansion, remodeling or alteration of existing facilities.

Hospital Based Home Care. This program provides chronically ill veterans with services in their own homes. A VA treatment team provides medical, nursing, social, dietetic and rehabilitation regimes and, trains family members in ongoing care of the patient.

Adult (Geriatric) Day Health Care. This program provides health maintenance and therapeutic activities in a congregate setting for veterans who would otherwise require continued and fulltime institutionalization. Advances in the understanding and treatment of certain illnesses of the aging now make it possible for many of these veterans to function independently with partial care offered by these centers.

Geriatric Research, Education and Clinical Centers (GRECC). The GRECC program consists of ten centers and represents an important aspect of the response to the health care needs of aging veterans. It serves to attract and develop superior staff in the field of gerontology and geriatrics and to advance and integrate research and educational achievements into the VA health care system. In addition to providing a balanced program of research, education and clinical care in the field of geriatrics, each GRECC is charged with providing a specialized research component with a particular focus such as neurobiology, immunology, endocrinology, behavioral disorders, depression/senility, cardiopulmonary diseases or rehabilitation. Studies by VA investigators in GRECCS and other geriatric research programs range from clinical investigations and the development of innovative health care delivery systems to high priority basic science studies designed to increase the body of knowledge concerning the basic biological process of aging. This, in turn, will form the foundation for future research aimed at delaying the age related degenerative processes that make the elderly so vulnerable to physical, functional and mental disorders. The VA is exploring a number of approaches to deal with the aging veteran situation, one of which is to reduce the demand for health care services by reducing the need for the them.

Mr. Chairman, the VA's research program is comprised of three components:

- Medical Research which provides opportunities for basic science and clinical investigation;

- Rehabilitation Research and Development which is dedicated to improving the quality of life and functional independence of physically disabled and infirm veterans and;

- Health Services Research and Development which places emphasis on research methods and data analysis strategies that are used within the framework of health services research including: technology assessment, operations research, economics, clinical decision making, clinical epidemiology and program evaluation.

It is our opinion that the VA is doing an admirable job regarding their research programs with respect to the aging. This is true although the VA research component received less than 2% of the total Department of Medicine and Surgery budget in Fiscal Year 1983.

It is not really possible to put an accurate price tag on the value of research, however, the VA's efforts and accomplishments over the years have certainly been commendable--highlighted in 1977 when the Nobel Prize for Medicine was shared by two VA researchers--one of whom, Andrew V. Schally, Ph.D., will provide testimony today.

Mr. Chairman, based upon the projected dramatic increase in the number of aging veterans and the simple fact that people are living longer than ever before--a life expectancy of 75 years--the VA will be faced with the reality that more and more veterans will be seeking medical care for a wide range of conditions which will be of a chronic and debilitating nature.

It should be anticipated that as the aging veteran population continues to increase, so will the number of sensory disabilities increase--such as speech and audiological conditions.

This situation has been recognized by the VA as evidenced by the high priority placed on research and development in speech and hearing impairments. The VA's goals in speech and hearing impairment are:

- to better understand the interaction between aging and an individual's ability to communicate effectively through speech and/or hearing;
- to develop valid and reliable speech and hearing evaluation procedures and;
- to develop and provide innovative devices or systems for the treatment of speech and hearing impairments.

The fruits of the VA's efforts in this area may be witnessed here this morning, in part, by the innovation of Remote Machine Assisted Treatment and Evaluation (REMATE) developed by the Audiology--Speech Pathology Service at the Birmingham, Alabama, VAMC under the direction of Gwenyth R. Vaughn, Ph.D., Chief of that Service.

REMATE is best described as a telephonic communication outreach health care delivery system. It is a computer system that makes supplementary treatment and evaluation and rehabilitation services available, assessable and cost effective nationwide. A telephonic drill session includes the communication modes of speaking, listening, reading and writing.

Mr. Chairman, this program has proved itself to be a viable alternative to the traditional face-to-face/clinician-patient treatment plan. Additionally, it has proven extremely cost effective and has enjoyed a great deal of patient satisfaction.

Recognizing VA's efforts and achievements in research related to the aged veteran, Mr. Chairman, the DAV, nevertheless, offers the following recommendations:

- that funding for VA's Health Services Research programs be significantly increased with an eye toward developing responsible alternative methods for meeting the needs and demand for care presented by the aging veteran population; and

- given the fact that older patients present a greater need for prosthetic and orthotic devices, funding for VA's Rehabilitation Research and Development program should be bolstered.

The DAV commends the VA's medical research efforts directed toward the aging veteran and looks forward to additional and continued breakthroughs that will enable our nation's aged, disabled veteran population to enjoy the highest quality of life and comfort.

In our view, Mr. Chairman, fulfillment of our nation's obligation to its aged veterans lies within VA's coordinated, Medical, Rehabilitation and Health Services Research programs.

Mr. Chairman, this completes my statement. Again, the DAV deeply appreciates having been given the opportunity to present our views on this most important subject.

* * *

PVA
PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

STATEMENT OF
R. JACK POWELL, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE
THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VETERANS ADMINISTRATION'S MEDICAL RESEARCH ON AGING

JUNE 13, 1984

Mr. Chairman and Members of the Subcommittee, it is a pleasure for Paralyzed Veterans of America to appear today and present the views and concerns of its members regarding the Veterans Administration's Medical Research Program on Aging. I am R. Jack Powell, Executive Director of PVA.

We appreciate the Subcommittee Chairman's efforts to conduct this necessary hearing here today. The PVA's concerns relate directly to the needs of aging spinal cord injured veterans. The Veterans Administration is in the unique position to incorporate into its program on aging an inclusive investigative research profile on the psychological, medical, sociological, and economic needs of aging spinal cord injured veterans.

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Studies reflect that for the most part, the SCI veteran has received rehabilitation and information only as it pertains to the initial acute, post traumatic and early phases of the injury. In the past, little attention was paid to the correlation between the spinal cord injury and the aging process.

This is true only because it was not believed in the early years, and for many subsequent years, by the medical professions that a person with a cord injury would be able to enjoy a long life. Today, life expectancy for an individual with a spinal cord injury is near that of a non-disabled person. The time is now for the VA to investigate what the consequences of aging and of a long life as a spinal cord injured person will be. The time is now because there now exists an aging SCI veteran population. The research should also include what the needs of an elderly person are, when he/she becomes spinal cord injured late in life.

The 1980 census data reports that 36 million people are over the age of 60, and it is expected that this number of Americans will more than double to 82 million persons in the next 50 years. It is essential to begin research programs concerning the aging veteran and non-veteran population. Included in any such research, we request that specific considerations be given to the needs and changing conditions of catastrophically disabled individuals. The Veterans Administration and society must begin preparations by gaining timely insights into the changing requirements of spinal cord injured veterans, so it can deal with and provide for the aging SCI a healthy, prolonged life with the least complications.

The Paralyzed Veterans of America's Spinal Cord Injury Research Foundation has provided grant funds for a study in this arena, it is our intention to share these results by working with the VA in this critical area of concern. We urge this Subcommittee and the VA to share in our concerns.

Today, I would like to depart from our usual approach in addressing our concerns. With your understanding and approval, I will attempt to present the eloquent remarks and written statement of Dr. George W. Hohmann, a charter member of PVA. Dr. Hohmann has become, by his vast experience, an expert in the area of the aging spinal cord injured veteran. He himself has encountered and is enjoying longevity of a life of over 40 years as a SCI veteran. We are certain that he will continue to pursue life and gracefully become an elder statesman some day. Unfortunately, Dr. Hohmann could not be here today for personal health reasons.

I am privileged to convey to you a brief biography of Dr. Hohmann. (His academic vita is attached for the record and for your information).

BIOGRAPHY - DR. GEORGE W. HOHMANN

Born in a small town in Texas during the Depression, George Hohmann acquired a strong determination to survive and an ability to direct his energies positively at an early age. When he was paralyzed in combat during World War II, he drew on these qualities to help him deal with what he describes as "the nuisances of paraplegia."

In 1946, Hohmann enrolled at the University of California, Los Angeles, where he earned successive degrees in psychology, culminating in his Ph.D. in 1955. His first job was staff psychologist, Spinal Cord Injury Service, at the Long Beach Veterans Administration Hospital. In 1962 he was appointed chief of the psychology service at the VA Medical Center in Tucson, Arizona, until his retirement in 1978. (Dr. Hohmann continues to serve the disabled community as a member of the teaching staff at the University of Arizona (Tucson) in the departments of Psychology and psychiatry.)

In addition to his career in the medical profession, Dr. Hohmann has also found time to serve as a member and consultant on various committees and boards. He was particularly influential as national consultant for the Veterans Administration, Spinal Cord Injury Service, in Washington, D.C. (1968-1978). A charter member of the Paralyzed Veterans of America, Dr. Hohmann has served since as a member of PVA's Spinal Cord Injury Research Foundation Board of Trustees.

A confirmed workaholic, Dr. Hohmann has authored or co-authored 32 articles printed in professional journals, the majority of which deal with paraplegia.

(Statement of George W. Hohmann follows)

STATEMENT OF
GEORGE W. HOHMANN, Ph.D
PROFESSOR EMERITUS, UNIVERSITY OF ARIZONA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS'AFFAIRS
REGARDING
VETERANS' ADMINISTRATION MEDICAL RESEARCH ON AGING
JUNE 13, 1984

Never before in the history of medicine have a significant number of spinal cord injured individuals who have sustained their disability in their youth lived to old age. The advent of antibiotics during WWII plus comprehensive medical and rehabilitation treatments developed in the Veterans Administration (VA) in the '40s and '50s have allowed a significant number of WWII veterans to survive forty to forty-five years following their injury. The comprehensive follow-up care and medical records in the VA make it possible at this time to undertake investigations of the interaction between spinal cord injury (and other catastrophically disabled such as multiple sclerosis, post polio, etc.) and the aging process. Significant advances have been made in gerontological research and care in the last several decades, but the scientific literature is almost silent on the interaction between long-term catastrophic disability and the usual problems experienced as people grow old. In the spinal cord injury literature, late or long-term complications are usually reported as those occurring five or ten years following injury. What are the problems of people who have lived with a spinal cord injury for four or five decades? At this point, only in the VA are there the resources to investigate these critical issues which will gradually become vital to the 300,000 to 500,000 estimated spinal cord injured individuals in the United States.

The development of the regional spinal cord rehabilitation and hospital system in the private sector in the late '60s and '70s, plus the establishment of its data system, does not have people whom they have followed for more than five years on the average; thus the only feasible place for these crucial special investigations is in the VA spinal cord injury system.

In the last two years a limited number of publications have appeared that address the topic of long-term complications of spinal cord injured indirectly. Because of the nature of the illnesses reported, they are frequently found in people who have been injured more than 20 years; however, age and length of time injured are not treated as independent variables in any reports that have come to my attention. Some examples of these reports follow.

Konsari, et al, reported in PARAPLEGIA (probably Vol. 20, #2, 1982) on the frequency of malignancies in the genital urinary (GU) tract of spinal cord injured veterans who have been injured upward of twenty years. They found the frequency of such malignancies to be about twenty times greater than that of the non-disabled male population of comparable age. These findings suggest that the less sophisticated early treatment of urinary dysfunction, poor infection control, use of indwelling catheters, etc., may be having the effect of greatly increasing the probability of malignancies of the GU tract of the aging group. It is to be hoped that with the more sophisticated methods of management of urinary dysfunction developed in the last twenty years, this finding may be reversed in subsequent generations of cord injured individuals. This possibility needs continuing investigation.

Three reports in PARAPLEGIA (Vol. 22, #1, 1984) which have just appeared from the Long Beach VAMC Spinal Cord Injury Service, have examined endocrine pathology in the spinal cord injured individuals who have been on dialysis for end-stage renal disease. Significant pathology in the endocrine system was demonstrated. There is also a discussion of osteomyelitis and the use of hyperbaric oxygen treatment in its control which shows this modality to be helpful. A third study on renal pathology in spinal cord injured individuals who have been treated for end-stage renal disease shows that infection and consequent amyloidosis explains much of the renal failure that leads ultimately to end-stage renal disease. This is not true of non-SCI ESRD patients. Again, in all of these reports the population generally is middle-aged or older and have been injured many years, but age and length of injury are not considered as principal variables.

In regard to the psychological, social, economic and family aspects of aging and spinal cord injury, even less is known. Studies recently completed at Portland State University (Lynn Phillips, PVA National Research Director, can give you the particulars of this work - funded by PVA Spinal Cord Injury Foundation) have investigated the quality of life and the needs and adjustment of older spinal cord injured individuals and their spouses. However, some of these individuals have not been injured long but were simply older than usual at the time of injury.

It is evident then that the existing spinal cord injury research and literature devotes itself almost exclusively to problems occurring in the first five years following onset of injury and reports little or nothing regarding the difficulties beyond that time. It is as though the assumptions have been made that once initial and early treatment and readjustment and rehabilitation have been achieved, the spinal cord injured individual's life goes on much as though the disability has little influence on the remainder of the person's life.

What seems to be needed at this point is a comprehensive survey of the types of difficulties in medical, social, family, vocational and economic areas, to name a few, that are being experienced by people over age 55 who have been spinal cord injured for more than twenty years. Such a survey should serve the purpose of defining some of the problems and suggest more focused and specific research into the interaction between chronic, long-term, catastrophic disability and aging. Based on clinical experience with the population under consideration, there follows a listing of some suggested problems that may need further investigation. As examples, five medical problems and five psycho-social problems will be mentioned.

MEDICAL

(1) The best statistics on mortality, morbidity and longevity of spinal cord injured individuals is that published by Nyquist and Bors, based largely on

WWII and the Korean War veterans, and published about 1965. There is a desperate need to continue to follow up and re-assess these data (now twenty years old) to understand, in a statistical sense, how long people are living, when they are dying, what they are dying of, and what their disabilities are.

(2) Infectious processes in the aging, long-term injured veteran are a crucial problem. There seems to be a high incidence of abscesses and other types of infections that may be manifesting themselves clinically as the patients' resistance is lowered by the aging process. Clinical cases where old imbedded missiles have erupted into active abacesses are known. Long healed decubitus ulcers suddenly seem to be opening up with infection pockets. Sites of old renal surgeries twenty or thirty years earlier are known to abscess. The development of amyloidosis in vital organs such as kidneys, liver, spleen and endocrine system secondary to such chronic infections, seem to be accounting for morbidity and mortality in this group.

(3) Malignancies. The report previously mentioned by Konsari, et. al, is suggestive that this group is highly at risk for developing malignancy of the GU tract. Clinical evidence suggests (but no data support) the notion that malignancies in other areas may also be much higher in this group than in the non-disabled population. Is this, in fact, so? This question can only be answered by competent data.

(4) Musculo-skeletal problems. A significant number of long-term spinal cord injured individuals seem to be developing arthritic and other inflammatory diseases in the shoulder girdle, cervical spine and arms. This seems to be more true of paraplegics than quadriplegics and is logical because of the

extreme amount of stress and trauma amount forced by the use of the shoulder girdle as the principal means of transportation, transfer and occupation over a period of several decades.

Is the incidence of traumatic arthritis in this group greater than that in the non-cord injured population? How much more disabling is it for this group who have no other means of moving about or caring for themselves? Osteoporotic bones fracture easily in all old people but is this more common in the subject population and are the complications greater?

(5) Neurological. A seemingly large number of neurological complications seem to be appearing in the older spinal cord injured individual. Carpal tunnel syndrome, ulnar nerve atrophy, ascending arachnoiditis, degenerative disc disease all seem to be showing up with considerable frequency in this population. The suspected reason is as evident as with the musculo-skeletal problems. Put simply, one cannot use arms to function for both arms and legs for forty to fifty years without paying some price. What is the price? Are there implications for newly injured individuals to spare themselves some of their excessive physical activity lest they develop more complications in their old age from traumatic arthritis in the shoulder girdle, for example?

PSYCHOSOCIAL PROBLEMS

(1) What is the quality of life of this group as age and increasing medical problems curtail their mobility, employability and social activities? Is this more extensive than with the non-catastrophically disabled elderly population? What are some of the remedies that might be undertaken if the

quality of life is poor? Are these people who may have led active lives now "shut-ins" and is the proportion in this population higher than in the general population? If so, what resources might be helpful?

(2) Loss of independence. As cord injured individuals become more disabled with age, that price is paid in independence, not only psychologically but physically and economically? Are people, once capable of providing all their own self-care, now having to depend on others for personal care? Are such care-givers available, what do they cost, are they family members, especially spouses who are also experiencing problems of growing old and are not as strong as they once were? What sources of assistance need be provided?

(3) Depression. Many older spinal cord injured individuals lived full, productive lives, had active careers, raised families and have been responsible community members now find themselves in the position of feeling useless, depressed, isolated and lonely. Such experiences are also commonly reported among non-disabled elderly populations. Is it quantitatively or qualitatively different for the catastrophically disabled? Programs exist in almost every community for senior citizens to combat such problems; are such resources also available to the catastrophically disabled? How might existing community programs to meet these needs of the elderly be modified to serve the catastrophically disabled?

(4) Family problems. For those catastrophically disabled individuals who require increasing physical assistance and psychological support, what family resources are available to meet these needs? The disgraceful solution to the problems of the disabled elderly being placed in nursing homes when there are

no family to care for them, or inadequate physical or financial resources, is widely discussed in our society. Can surrogate families be developed where none exist to avoid the almost inevitable course of the aging catastrophically disabled person going into nursing homes. How supportive are families where catastrophic disability has long existed? More or less than in the general population?

(5) Economic problems. Economic needs of the elderly are constantly under discussion and there are many advocacy groups dealing with these problems for senior citizens in general. What are the economic problems of the long-term catastrophically disabled individuals who may not have been able to have a productive earning life and accumulate some resources for their old age? How do they manage to pay for their extraordinarily heavy medical expenses? Where do they get the supplies and equipment that is required to manage their spinal cord injury? What resources are available? What resources are needed and how can they be provided?

SUMMARY

Virtually no information exists about the interaction between the aging process and long-term spinal cord injury. For the first time in the history of medicine there is a need and an opportunity to investigate these problems. With the most comprehensive follow-up system in the country looking at spinal cord injured individuals, the Veterans Administration is the most logical place to begin such investigations. There is a need for a general survey of what problems the aging, long-term injured, spinal cord injured person is experiencing. Based on clinical experience, five medical problems and five psychosocial problems are mentioned as examples of the kind of research that needs to be done in this area.

Thank you. Please do not hesitate to contact me for further information.

ACADEMIC VITA

June, 1975

Name: George W. Hohmann, Ph.D.

Date and Place of Birth: December 30, 1923 at Waka, Texas

Education: West Texas State University, Canyon, Texas, 1941-43.
U.S. Army - 1943-46.
Ohio State University (Army Specialized Training Program) 1943-44.
University of California at Los Angeles - 1946-55.
June, 1948 - B.S. in Psychology
Feb., 1953 - M.A. in Psychology
Feb., 1955 - Ph.D. in Psychology
Dissertation: "Stress and Spasticity in Paraplegia".
Director: Roy M. Dorcas, Ph.D.

Academic and Professional Appointments:

1955-62 Staff Psychologist, VA Hospital, Long Beach, CA.
1957-62 Assistant Clinical Professor of Psychology, University of CA at Los Angeles, Los Angeles, CA.
1958-59 Assoc.Professor in Psychology, Long Beach State University, Long Beach, CA.
1959-63 Member, Scientific Advisory Board, Spinal Cord Research Foundation, Long Beach, CA.
1961-62 Consultant, Rancho Los Amigos Hospital, Downey, CA.
1962-present: Chief, Psychology Service, VA Hospital, Tucson, AZ.
1963-present: Lecturer to Adjunct Prof. in Psychology, University of AZ, Tucson, AZ.
1968-present: Faculty Member, Spinal Cord Injury Post Graduate Course, VA Central Office, Washington, D.C.
1968-present: National Consultant, VA Spinal Cord Injury Service, Washington, D.C.
1970-present: Consultant, Good Samaritan Hospital, Spinal Cord Injury Center, Phoenix, AZ.
1972-present: Member, Scientific Advisory Board, Paralyzed Veterans of America, Washington, D.C.
1973-present: Adjunct Professor of Psychiatry, College of Medicine, University of Arizona, Tucson, AZ.

Major Fields: Clinical Psychology, Rehabilitation Psychology.

Honors/Awards: 1952-55 Veterans Administration Stipend Traineeship.
1953 Annual Achievement Award, Association for Physical and Mental Rehabilitation.
1975 "Psychologist of the Year" Award, AZ State Psychological Association.

Teaching Responsibilities:		No. of Students
1969-70	Psychology 362 - Practicum in Clinical Assessment Techniques	10
1970-71	Fall-Psychology 383-Practicum in Individual Psychotherapy	10
1971-72	Fall-Psychology 383-Practicum in Individual Psychotherapy	10
1972-73	Psychology 383-Fall-Practicum in Individual Psychotherapy	10
1973-74	No formal classroom teaching responsibilities. In the fall, I was assigned individual supervision of overflow cases from the [illegible]	

Clinc. During the spring semester I supervised five students who were continuing there cases from the Practicum in Psychology 383. In addition, it should be noted that I also supervise approximately six University of Arizona graduate students in Clinical Psychology for their practicum training assigned to the VA Hospital.

University and Professional Committees:

I have not served on any University committee in the past five years. For professional and research committees service, see Academic and Professional Appointments.

Thesis and Dissertation Committees:

During the past five years, I have served as director for eight Ph.D. dissertations and one Masters thesis in Psychology. Additionally, I have served as a committee member on 14 Ph.D. committees in Psychology and have been a committee member on one Masters committee in the Department of Mathematics. Currently I am serving as dissertation director for two Ph.D. candidates and as a committee member for nine Ph.D. candidates in Psychology. Also, I am currently serving as a committee member for two Masters degree candidates in the College of Nursing.

Publications and Works in Press:

Hohmann, G.W. Emotion and reflex activity. Journal of Physical/Mental Rehabilitation, 1955, 9, 163-167.

Hohmann, G.W. A stoic faces stress. In Seward, G.H.(Ed.) Clinical Studies in Culture Conflict. New York: Ronald Press, 1958.

Hohmann, G.W. and Munoz, C.A. Use of drugs in treatment of mental and emotional disorders in spinal cord injury. In, Proceedings Ninth Annual Spinal Cord Injury Conference. Washington: Veterans Administration, 1960.

Porter, R.W., Hohmann, G.W., Bors, E., French, J.D. Cordotomy for pain following cauda equina injury. Archives of Surgery, 1966, 92, 765-770.

Hohmann, G.W. Some effects of spinal cord lesions on experienced emotional feelings. Psychophysiology, 1966, 3, 143-156.

Hohmann, G.W. Psychological problems of the seriously disabled. In, Proceedings Workshop on Nursing Problems with the Seriously Disabled. Tucson,AZ: University of Arizona, College of Nursing, 1963.

Hohmann, G.W. Role of the psychologist in the total rehabilitation of spinal cord injured individuals. In, Proceedings First Spinal Cord Injury Post Graduate Course, Washington: Veterans Administration, 1968.

Hohmann, G.W., Baker, J.M., and Ogilvie, L. Preliminary findings in the use of veterans community adjustment inventory. Newsletter for Research in Psychology, 1970, 12, 9-11.

Hohmann, G.W. The role of the psychologist in the spinal cord injury program. In, Proceedings 17th Annual Spinal Cord Injury Conference. Washington: Veterans Administration, 1970.

Hohmann, G.W. Consideration in management of psychosexual readjustment in the spinal cord injured male. Rehabilitation Psychology, 1972, 19, 50-58.

Hohmann, G.W. Consideration in management of psychosexual readjustment. In, Proceedings of the 18th V.A. Spinal Cord Injury Conference. Washington: Veterans Administration, 1972.

Hohmann, G.W., Morgan, E.D., and Davis,J.W. Rehabilitating the person with spinal cord injury: a source book. Washington: U.S.Government Printing Office, 1972.

Hohmann, G.W. Sex and the cord injured male. Paraplegia News, 1973, 26,16-18

Hohmann, G.W. Commentary on sex among patients with spinal cord and/or cauda equina injuries. Human Sexuality, 1973, 7, 238.
Hohmann, G.W. Sex and the spinal cord injured male. Accent on Living, 1973, 17, 22-35.
Hohmann, G.W. Sexual counseling for the cord injured. In, Proceedings of a Seminar on Serving the Spinal Cord Injured Client. Charleston: West Virginia Division of Vocational Rehabilitation, 1973.
Hohmann, G.W. Professional role models. In, McCauley, R.J. Sex: Rehabilitation's Stepchild, Chicago: National Paraplegia Foundation, 1974.
Griffith, E.R., Trieschmann, R.B., Hohmann, G.W., Cole, T.M., Tobis, J.S. and Cummings, V. Sexual dysfunctions associated with physical disabilities. Archives of Physical Medicine and Rehabilitation, V56, pp 8-13, January, 1975.

The following works are completed and have been accepted by the indicated journals:

Hohmann, G.W. The disabled psychologist in the spinal cord injury center. Rehabilitation Psychology, fall, 1974.
Hohmann, G.W. Psychological aspects of treatment and rehabilitation of the spinal cord injured person. Clinical Orthopedics and Related Research, January, 1975.
Hohmann, G.W. Reactions of the individual with a disability complicated by a sexual problem. Archives of Physical Medicine and Rehabilitation. Submitted and returned for minor revisions. Resubmitted, but do not have anticipated publication date.
Hohmann, G.W. The insider-outsider position and the maintenance of hope. Rehabilitation Psychology. NOTE: This paper was delivered at APA at New Orleans, has been requested by the editor of Rehabilitation Psychology, and has been submitted.
Morgan, E.D., Hohmann, G.W., and Davis, J.E. A study of psychosocial rehabilitation in V.A. Spinal Cord Injury Centers. Rehabilitation Psychology. NOTE: This paper has been requested by the editor of this journal, is due for publication some time in the spring or summer of 1975.

Unpublished Papers and Reports:

Hohmann, G.W. Cultural Factors in Psychodiagnosis. Monterey, CA: Western Psychological Association, August 31, 1958.
Hohmann, G.W. Psychological Services in a Chronic Diseases Hospital. San Jose, CA; Western Psychological Association, September 1, 1960.
Hohmann, G.W. World Through the Patient's Window. Long Beach, CA: National Recreation Association, June 20, 1958.
Hohmann, G.W. Reactions to Loss. Tucson, AZ: Symposium on Restorative Nursing in Strokes and Other Chronic Disease, St. Mary's Hospital, September 15, 1966.
Hohmann, G.W. Adjustment to Chronic Disease and Illness. Phoenix, AZ: Arizona State Nurses Association, May 13, 1965.
Hohmann, G.W. Psychological Management of the Cord Injured Patient. Durham, NC: College of Medicine, Duke University, July 7, 1968.
Hohmann, G.W. New Directions in Psychosocial Rehabilitation. Los Angeles, CA: Paralyzed Veterans of America, July 28, 1971.
Hohmann, G.W. In-Hospital Rehabilitation Through Training of Spinal Cord Injured Patients in Computer Programming and Terminal Operation. Washington: American Psychological Association, Sept. 6, 1971.
Hohmann, G.W. Considerations in Management of Psychosocial Readjustment in the Cord Injured Male. Boston: International Medical Society for Paraplegia, College of Medicine, Harvard University, Oct. 6, 1971.

Hohmann, G.W. Impact of Staff Attitudes on Patient Care, Recovery, and Rehabilitation. St.Louis: College of Medicine, Washington University, Oct. 8, 1971.

Hohmann, G.W. Recommendations for Programs of Psychosocial Support in the Rehabilitation of the Severely Disabled. St.Louis; College of Medicine, Washington University, Oct. 9, 1971.

Hohmann, G.W. Psychosocial Rehabilitation: Changing a System. Tempe, AZ: Department of Psychology, Arizona State University, Oct. 28, 1971.

Hohmann, G.W. The Physiology and Psychology of Sexual Adjustment. Memphis, TN: 2nd Spinal Cord Injury Course in Psychosocial Rehabilitation, Veterans Administration, Nov. 17, 1971.

Hohmann, G.W. Some Problems Experienced by the Cord Injured in the Establishment of New Families. Castle Point, N.Y.: 3rd Spinal Cord Injury Course in Psychosocial Rehabilitation, Veterans Administration, April 11, 1972.

Hohmann, G.W. The Cord Injured Professional in the Spinal Cord Injury Center: Views and Fallacies. Honolulu: American Psychological Association, Sept. 3, 1972.

Hohmann, G.W. Comprehensive Rehabilitation of the Cord Injured Person. Charleston, WV: Region III Counselor Training Progtam, Symposium on Spinal Cord Injury, Oct. 26, 1972.

Hohmann, G.W. Emotional Reactions to Cord Injury. Miami, FL: American Academy of Orthopedic Surgeons, Dec. 10, 1972.

Hohmann, G.W. Sexual Counseling for the Disabled. Indianapolis; National Paraplegia Foundation, June 17, 1973.

Hohmann, G.W. Reactions of the Individual with a Disability Complicated by Sexual Problem. Washington: American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation, Oct.24, 1973.

Hohmann, G.W. Sexual Functioning and the Spinal Cord Injured Male. Tucson, AZ: Arizona Occupational Therapy Association, Sept. 22, 1973.

Hohmann, G.W. Sex and the Physically Disabled. Tucson, AZ: College of Medicine, University of Arizona, Dec. 19, 1973.

Hohmann, G.W. Psychosocial Considerations in the Treatment of Sexual Problems in the Physically Disabled Individual. New Orleans: American Psychological Association, Aug. 31, 1974.

Hohmann, G.W. The Insider-Outsider Position and Rehabilitation Issues: A Symposium in Honor of Tamara Dembo. New Orleans: American Psychological Association, September 1, 1974.

Hohmann, G.W. Psychosocial Rehabilitation of the Cord Injured Male. Castle Point, NY: Veterans Administration Post Graduate Course on Comprehensive Rehabilitation of Spinal Cord Injured Individuals, Sept. 17-20, 1974.

Hohmann, G.W. Psychological Factors in the Management of Chronic Painful States. Castle Point, N.Y.: Veterans Administration Post Graduate Course on Comprehensive Rehabilitation of Spinal Cord Injured Individuals, Sept.17-20, 1974.

Hohmann, G.W. Emotional Reaction to Severe Physical Loss. Castle Point, NY: Veterans Administration Post Graduate Course on Comprehensive Rehabilitation of Spinal Cord Injured Individuals, Sept. 17-20, 1974.

Other Professional Activities:

President, Long Beach, CA Psychological Association, 1957.

Special Representative from the APA to the National Society for Crippled Children and Adults, 1958-60.

Member, Executive Council, Arizona State Psychological Association, 1963-70, and President from 1968-69.
Jury Reader, Rehabilitation Psychology, 1972 - present.
Member, Advisory Council, Spinal Cord Injury Hemodialysis Unit, VA Hospital, Long Beach, CA.
Member, Research and Education Committee, 1968-present, Tucson VA Hospital, and Chairman, 1966-68.
Member, Education and Training Committee, Tucson VA Hospital, 1973-present.

In addition to the unpublished papers and reports described previously, I am also very active in making professional presentations to various professional and lay groups in the Tucson area. These are frequent, often once or twice a month, and too numerous to include in this vita.

ADDENDUM - June, 1975

Griffith, E.R., Trieschmann, R.B., Hohmann, G.W., Cole, T.M., Tobis, J.S., and Cummings, V. Sexual dysfunctions associated with physical disabilities. Arch. of Physical Medicine and Rehabilitation, 1975; 56, 8-13.

Morgan, E.D., Hohmann, G.W., and Davis, J.E.,Jr. Psychosocial rehabilitation in VA spinal cord injury centers. Rehabilitation Psychology, 1974; 21, 3-27.

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Unpublished papers and reprints:

Hohmann, G.W. Techniques for sexual interviewing and case history-taking with the disabled. Rochester, NY; Genesee Region Family Planning Program, University of Rochester, March 16, 1975.

Hohmann, G.W. Problems in initiating a psychosexual reeducation program in a rehabilitation center. Rochester, NY; Monroe County Hospital, March 17, 1975.

Hohmann, G.W. Psychosocial aspects of spinal cord injury rehabilitation. Palo Alto, CA: V.A.Hospital and College of Medicine, Stanford Univ., April 9, 1975.

Hohmann, G.W. Comprehensive programs for psychosocial rehabilitation of the spinal cord injured. Miami, FL.: College of Medicine, University of Miami, May 17, 1975.

Talks:

Hohmann, G.W. Sexuality and the Handicapped. Tucson, AZ: College of Nursing, University of Arizona, Oct. 9, 1974.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO THE VETERANS ADMINISTRATION'S MEDICAL RESEARCH PROGRAM ON AGING

WASHINGTON, D.C. JUNE 13, 1984

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 1.97 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, the Veterans Administration's Geriatric Research, Education, and Clinical Centers (GRECCs) program was created in 1973 to provide centers of excellence to teach and conduct research on aging in a clinical context which would have a positive affect on the provision of health-care services to older veterans. In 1975, the GRECC program was enhanced when an Assistant Chief Medical Director was designated to head the newly-created Office of Extended Care. Then, in 1978, the Administrator established the Geriatric Fellowship Program to attract highly qualified physicians who would pursue training and research in geriatrics. Between 1975 and 1978, the following eight VA medical centers were designated as GRECC sites on

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the basis of the interest and experience of their staff in particular geriatric issues and problems: (1) Bedford, Massachusetts; (2) Little Rock, Arkansas; (3) Los Angeles (Wadsworth), California; (4) Minneapolis, Minnesota; (5) Palo Alto, California; (6) St. Louis, Missouri; (7) Seattle (American Lake), Washington; and (8) Sepulveda, California. All medical centers with GRECCs are affiliated with medical schools.

Mr. Chairman, realizing that the number of veterans 65 years of age and older would reach 9 million by the year 1990, Congress in its wisdom, and this Subcommittee and the full Committee in particular, saw to it that Title II of Public Law 96-330, the "Veterans Administration Health Care Amendments of 1980," authorized expansion of the GRECC program up to 15 GRECCs and established a Geriatrics and Gerontology Advisory Committee (GGAC). However, and unfortunately, neither the necessary funding nor staffing were provided and no additional GRECCs were funded until the fiscal year 1984. Now, two additional GRECCs are to be activated--one at Durham, North Carolina and one at Gainsville, Florida. At the present time, the Veterans Administration envisions that the 15 GRECCs authorized by Public Law 96-330 will be in operation by the fiscal year 1988 or 1989.

Mr. Chairman, according to an article in the May 15, 1984, edition of U.S. Medicine, entitled "VA Aging Plan Shows Growth Needs," by Nancy Tomich, "Thirty Geriatric Research, Education, and Clinical Centers (GRECCs) should be established by 1990 and should increase by 60 percent the number of trainees over the current level." The additional GRECCs would all be located in medical centers affiliated with medical schools and distributed across the country. The number of GRECCs needed and their locations has been fine tuned by Medical District Initiative Program Planning (MEDIPP) in conjunction with the GGAC. The VFW must accept these findings. However, we do have some observations regarding the GRECC program.

Since the passage of Public Law 96-330, the VFW has been critical of the slow expansion of the GRECCs. According to the Veterans Administration, there now exists the urgent need and the formidable task of increasing the number from ten in 1985 to 30 in 1990. If we are to see such an ambitious undertaking through to fruition in the time frame required, in our opinion, several steps must obviously be initiated almost immediately. Funding and personnel authorizations must be greatly enhanced for the upcoming fiscal year and the out years. This funding should then be a separate line item under medical care. The recruitment of physicians with expertise in disciplines applicable to geriatrics and gerontology or for such training must be accelerated. More emphasis could perhaps be placed on seeking out physicians retiring from the Armed Forces or those who have otherwise fulfilled their service commitment. Then, as the former Chief Medical Director, Dr. Donald L. Custis, testified before this Subcommittee previously, the Veterans Administration "...must be granted more flexibility in the management of these centers."

Mr. Chairman, not only is the veteran population aging, but by the turn of the century almost 20 percent of our entire population will be age 65 or older. The need to accelerate research with respect to Alzheimer's disease, diabetes, chronic ischemic heart disease, chronic obstructive lung disease and the increased susceptibility of older persons to certain infectious diseases, among others, is obvious.

In the cited U.S. Medicine article, the Administrator of Veterans Affairs, the Honorable Harry N. Walters, has laid out the needs of older veterans. In addition to more GRECCs, by the year 2000, a 68 percent increase in hospital beds will be needed with special geriatric evaluation units at each medical center, outpatient clinics should be able to support 26 million visits "with appropriate prevention and geriatric specialized services," extended care programs must be increased with "appropriate linkages to non-VA community programs for the elderly," and a comprehensive program to improve access and referral between VA and non-VA services.

The cost of the VA Aging Plan projects an increased funding level of $11 billion for the VA by 1990 and an additional $6 billion by the year 2000 or a total VA budget by then of some $42.2 billion.

Mr. Chairman, how much of the plan and the cost will be acceptable is questionable at this time. However, it is obvious that the present medical care budget is wholly inadequate if the needs of older veterans are to be met. The full Committee's report to the Committee on the Budget, Committee Print No. 55, dated March 8, 1984, made this abundantly clear in stating: "...Without anticipating the estimates and projections to be announced, it appears that the facilities which the Veterans' Administration presently operates, and which it plans to build or renovate with the funds requested in its fiscal year 1985 budget request, will not accommodate by any measure the anticipated demand for services over the next 20 years."

Mr. Chairman, our current VFW Resolution No. 607, entitled "Geriatric and Extended Care," appended to my testimony, calls for expanding and funding the geriatric and extended care capability of the Veterans Administration. In addition, one of our priority goals addresses increased medical care for older veterans.

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

Resolution No. 607

GERIATRIC AND EXTENDED CARE

WHEREAS, in 1980, the Congress authorized the establishment of fifteen Veterans Administration health care facilities as centers of geriatric research, education and clinical activities (GRECC); and

WHEREAS, it is recognized that current VA extended care capability cannot meet present demands of the eligible aging veteran; and

WHEREAS, VA medical district planning studies reveal an awareness of that deficiency and have indicated the need to expand long term care capability incrementally through 1990; and

WHEREAS, the Congress must be receptive to the budget planning process necessary to accomplish this recognized need without sacrificing the level and quality of acute health care for veterans; now, therefore

BE IT RESOLVED, by the 84th National Convention of the Veterans of Foreign Wars of the United States, that the Veterans Administration's comprehensive plan to expand geriatric and extended care capability for the aging veteran be approved and funded.

Adopted by the 84th National Convention of the Veterans of Foreign Wars of the United States held in New Orleans, Louisiana, August 12-19, 1983.

Resolution No. 607

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CONGRESSMAN HAMMERSCHMIDT TO VETERANS' ADMINISTRATION

Question. 1. The V.F.W. witnesses used a figure of $11 billion as being needed for geriatrics for the VA by 1990. To your knowledge has this figure surfaced in VA figures prior to this testimony? Is it a reasonable figure or an outside "dream" figure?

Answer. I do not believe this figure has ever surfaced in any VA briefing and cannot determine its source.

The President's 1985 Budget estimates that $10.3 billion will be required for VA medical care in Fiscal Year 1989, the farthest year projected. While this figure approaches the amount you referenced, it is for all care, not just the cost of care for the elderly.

Question 2. The witnesses of the Blinded Veterans Association suggested that one GRECC be considered primarily with elderly blind veterans. What is VA's response?

Answer. Recognizing that care, treatment, and rehabilitation of all blind veterans (including elderly ones) is a special need, the VA appreciates the suggestion that one GRECC be concerned primarily with elderly blind veterans. It seems entirely possible that in addition to investigator initiated research requests from existing GRECCs, that a VA medical center desiring to host a GRECC might suggest this area of focus in response to a future solicitation. It is the combination of talent, interest, expertise, and accomplishment at each GRECC that determines what its specialty focus is. Each GRECC determines its own specialty focus (foci), subject to final ratification and approval by Central Office, in order to achieve a national balance in the GRECC program. There must be a strong history of solid accomplishment in reseach, education, and clinical care in a particular speciality area and strong potential for continued achievement in order for the Administrator to designate a GRECC. In addition there must be long term care clinical training experiences for residents, interns, and allied health trainees at the hosting VAMC and the ability to attract top flight scientists to the GRECC program.

Question 3. What is VA's comment on the testimony of Congresswoman Snowe that VA Medical Centers have no consistent policy with respect to treating Alzheimer's Disease?

Answer. There is no treatment known that will alter the course of Alzheimer's disease. What is done is to provide support to the patient and family in managing the behavioral and social problems that arise. It is generally held that it is best for the patient to be maintained at home, or in the least restrictive environment, as long as possible. Most of the initial support measures therefore take place outside the hospital. Alzheimer's dementia is a progressive disease. As the disease progresses, a point is invariably reached when the patient can no longer be maintained at home and needs institutional care.

The admission of Alzheimer's patients to VA medical centers is not based solely on diagnosis or stage of disability. In addition to clinical judgment of medical need for admission of eligible veterans, available resources and alternatives are considered.

A veteran with Alzheimer's Disease whose spouse has died and who has few or no other family members to provide care is likely to be admitted at a relatively early stage of the disease. On the other hand, a veteran who has a spouse and family members who can provide care in the home with medical care provided by outpatient treatment at the VA medical center is likely to be admitted at a relatively later stage of the disease. Whether Alzheimer's patients are admitted immediately or placed on a waiting list will also vary from one medical center to another depending upon the availability of an appropriate bed, either hospital or nursing home.

Question 4. What is VA's comment on the suggestion that treatment of Alzheimer's Disease deserves a priority over other conditions or diseases insofar as the VA medical program is concerned?

Answer. Congresswoman Olympia J. Snowe has introduced legislation, H.R. 4273, in the House, and an identical bill, S. 2220, has been introduced in the Senate, which mandates that the Veterans Administration give priority to the treatment of Alzheimer's Disease over other conditions or diseases.

The array of services proposed in this legislation—comprehensive outpatient servcies, counseling and support for family—is clinically sound and is supported by the VA. A Program guide on dementia which reflects this approach to care, is currently being prepared for publication and distribution to all VA medical centers.

However, the VA does not support the proposal to give priority to the treatment of veterans with Alzheimer's Disease or related disorders. Designating priority care to veterans with Alzheimer's Disease would be unique in title 38 in that the beneficiaries would be designated by a disease rather than by an event related to a person's status as a veteran. The legislation would give veterans with Alzheimer's Disease the same entitlement to care as legislatively sanctioned priority groups, such as former prisoners of war.

The major effect of the proposed legislation would be to define a group of veterans 50–64 years of age who could receive hospital and nursing home care without asserting that they cannot defray the cost of care and, more importantly, would entitle them to outpatient care at a higher priority than nonservice-connected veterans.

The VA recognizes the tragedy and suffering that accompany Alzheimer's disease, affecting both the patient and his/her family. We also recognize, however, the tragedy and suffering that accompany many other illnesses.

The VA already provides care to many patients with dementia. The VA does not endorse creation of a special class of beneficiaries, whose eligibility for care was not based on existing legislatively-sanctioned, eligibility requirements.

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